#14-475 (456)

Original: 2294

October 22, 2002

Westmoreland County Personal Care Home
Administrator's Association
100 Bristol Lane
Irwin PA 15642

Office of Licensing & Regulatory Management
Room 623 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

Dear Office of Licensing & Regulatory Management,

We appeal to you: **STOP THE PROPOSED REGULATIONS!!** We, the providers of the Westmoreland County Personal Care Home Administrator's Association, have attempted to have our voice heard since March 2001 when the first draft was released. There have been countless hours spent in meetings with the Department of Public Welfare Advisory Committee, Office of License and Regulatory Management, and other statewide professional organizations. We have reviewed the regulations, offered suggestions and repeatedly asked that our voice be heard. After a year and a half of discussions, we feel that nothing has been accomplished because our voice has fallen on deaf ears! Our consensus critique for Chapter 2600 is attached – our official written public comment.

In meeting with Teleta Nevius, we were assured that the intention of the proposed regulations was not to close homes. A cost analysis done by our association proves that homes would still be put out of business by these proposed regulations. In Westmoreland County this amounts to 86 homes which serve 2063 residents, 364 which are SSI recipients.

ENFORCE OUR CURRENT REGULATIONS – DO NOT OVER REGULATE! The release of the Auditor General's report seemed to fuel the fire. We contend that there where no incidents that occurred that were not covered by our current regulations. The problem is not the current Regulations – it is the lack of enforcement of the regulations by the Department of Public Welfare. There are approximately 34 inspector for 1776 homes. Our inspectors obviously do not have the support of the state.

WE ARE CURRENTLY FOLLWING A **SOCIAL MODEL** AND SHOULD REMAIN THAT WAY. The push toward the Medical Model by the proposed regulations would require personal care homes to have more stringent staff training than nursing homes. Over regulation by countless policies and procedures would increase cost that will be passed on to the residents. We know this would result in a loss of choice for our residents and a decrease in the quality of care – the exact opposite of their intention: to **improve** the health, safety, and welfare of our residents.

We demand, for the sake of our residents and our homes, that these regulations be revisited, reviewed, and rewritten. THE REGULATIONS AS PROPOSED **MUST BE STOPPED!**

Respectfully Submitted,

Westmoreland County Personal Care Home Administrator's Association
Enclosures (2)

2620
Policy and Procedures

2620.5
Civil rights Policy & Procedures
for applicants, staff, residents

2620.37
Activities Program
Program of activities

2620.55
Fire protection and safety
(d) emergency evacuation plan

2600
Policy and Procedures

2600.26
Reportable Incidents
for prevention,reporting, notification, investigation, and management of reportable incidents

2600.31
Notification of rights and complaint procedures
(b) complaint procedures
(f) investigation of complaint procedures
(f) Complaint appeals procedures

2600.58
Staff Training and Orientation
1 (I) evacuation procedures
1 (iv) Smoking safety procedures
3 Emergency Medical Plan procedures
4 Personal policies and procedures
14 (ii) Implementation of Support Plan

2600.59
Staff Training Plan
Plan for developing and conducting staff training plan

2600.60
Individual Staff Training Plan
Plan for developing and conducting individual staff training plan

2600.98
Indoor activity space
(c) plan of activities

2600.106
Swimming Areas
2 protect the health and safety of the residents in regards to swimming

2600.107
(a) emergency procedures developed and approved by qualified fire, safety and local emergency management offices
(b) reviewed and updated annually

2620
Policy and Procedures

2600
Policy and Procedures

(c) diaster plan

2600.109
Firearms and weapons
5 Safety and access policy

2600.143
Emergency Medical Plan
(a) a plan that ensures immediate and direct access to emergency medical care for each resident

2600.144
(f) fire safety procedures to include designated smoking area

2600.184
Accountability of medication and controlled substances
(a) Safekeeping of medications
including policy on documenttion, investigation and access.

2600.181 to 2600.188
Medications
Policy and procedures regarding these issues will need developed by each facility

2600.201
Safe management techniques
(b) quality improvement program
to review, assess and analyze the homes ongoing steps to positively intervene when a resident's behavior endanagers resident, staff or others.

2600.223
Description of services
(a) written description of services and activities that the home provides from admission to discharge

2600.243
Record retention and disposal
Closure and storage of original or reprographic reproduction of resident records.

2600.244
Record Access and Security
(b) record accessibility, security, storage, authorized use, release, who is responsible.

Statewide Provider Organizations Statement on Proposed Regulation CH. 2600

The attached list of individuals participated in the following statement.

The reasons for the following statements and recommendations are:

- No providers, residents or inspectors were involved in the actual writing of the regulations
- To preserve existing homes because the cost to implement the requirements in Chapter 2600 could effectively put nearly 40% of homes out of business and has the potential to displace nearly 22,000 residents without funding the mandates.
- Disappointment with the Chapter (CH.) 2600 published regulations because very few suggestions were incorporated
- No notification was sent to personal care homes when they were published
- PCHs are a social model of housing and services ***not*** a medical model of care
- No grandfathering of existing buildings was considered

1. **We disapprove of the proposed CH. 2600 regulations as is, and propose to enhance the current regulations, CH.2620, in the following areas:**

These suggestions to CH. 2620 are intended to safeguard and promote the health, safety, well-being, rights, choices and dignity of each PCH resident.

- We support enhanced administrator training – 60 hours classroom, 80-hour on-the-job training for new administrators. We further support competency based testing for administrators.
- We support staff training combined with supervised in-house training
- We are committed to the development of an optional state-approved medication training program that can be offered in-house, that would certify unlicensed personnel to administer medications. If this takes legislative action, we are committed to leading this effort. This course should be offered at cost.
- We support the DPW's decision to implement the current enforcement fines and penalties and we ask for the adoption of the Advisory Committee's January 10, 2002 recommendations for enhanced enforcement.
- With respect to fire safety, we would recommend that the home have the option of using simulated drills as approved by a fire safety expert or actual drills to a point of safety rather than the excessive requirements in CH. 2600 (e.g., 2.5 min evacuations to outside areas which could potentially put residents' health and safety at risk).
- The direct care staff are those staff who directly assist residents with personal care services and tasks of daily living as defined in CH. 2620.

2. **We support the hiring of a sufficient complement of inspectors to enforce the CH. 2620 regulations as they were intended.**

3. **The Department of Public Welfare must increase the State Supplement to SSI residents in PCHs to a total benefit of at least $60 per day in addition to their personal needs allowance. Government mandates cannot be implemented until this is accomplished.**

October 23, 2002

2600 Regulation Meeting

Easy Living Estates

	Name	Organization / PCH
1	Margaret Cramer	Villa Angela @ St. Anna Home Greensburg, Pa 15601 West Reg PCH Admin Ass.
2	Wanda Hallen	The Heritage @ Siemons Lakeview Wayne County
3	Flora Hudson	Chellen Manor Hulton
4	Eugene Hudson	Chellen Manor Hulton
5	Clarence "Shelly" Smith (SER C.G.A.) Vic. Pres	5th & Broad Street Residence Phila Pa.
6	Judy Reynolds	Cedarwood / NAPCHAA
7	Lynn Wright	Windsor Place & Knight Rest Home / NAPCHAA NAPCHAA
8	Matt Harvey	Windsor Place / NAPCHAA
9	Rita Clark	Country Manor Living
10	Valerie Angeli	The Patriot
11	Ruth Shaffer	Shaffer's Countryside Assisted Living
12	Whitney Kauffman	Country Meadows / CALM
13	Harvey Everett	CALM
14	Mary Andreo	Assisted Homes Westmoreland County PCH Admin. Assoc
15	Ted Tinker	Country Meadows / CALM
16	Mary Jo Wright	Stone Brook
17	Elgin Pantchelle	Carmella's House - NCPCHAA
18	Rhonda Kaufman	Ringgold Residential Care - NCPCHAA
19	Carol Wing	Seneca P.C.H.
20	WALT YOUNG	St. Clair Hosp. P.C. Providers
21	Mark Sayre	Sunnyland Retirement Homes Inc.

Easy Living Estates

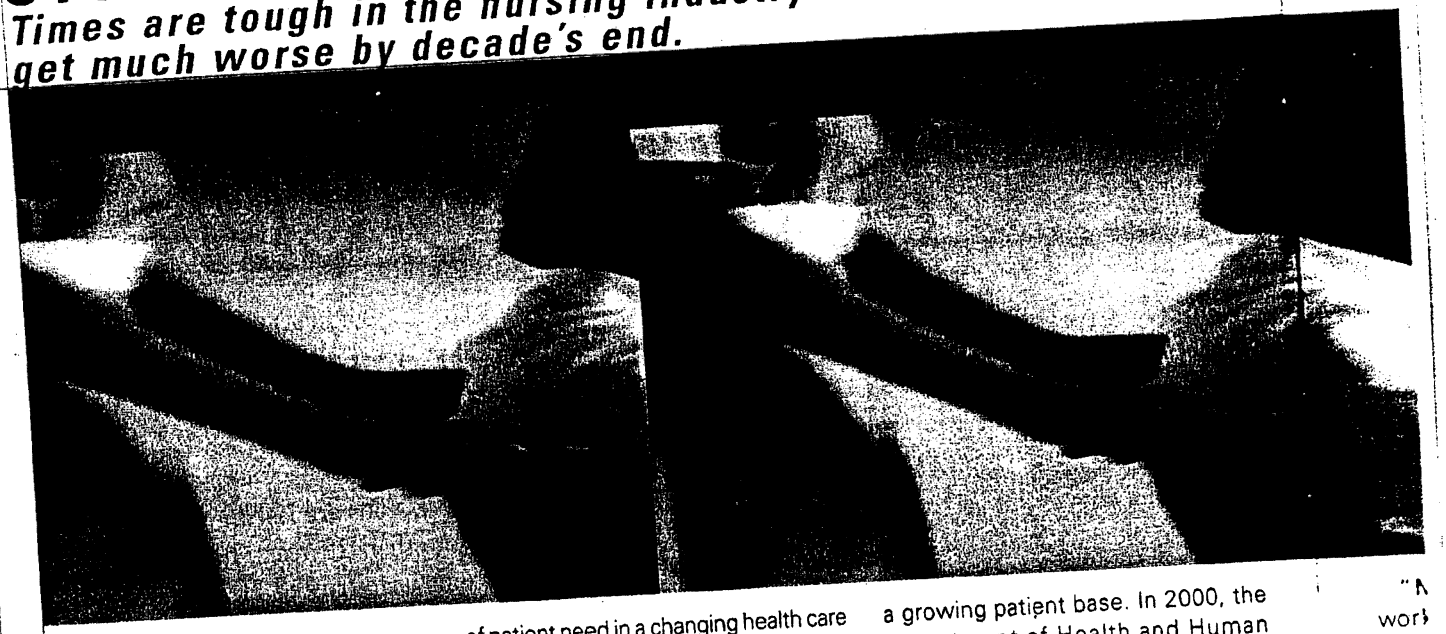
October 23, 2002

2600 Regulation Meeting

22	Patricia A. McNamara	PA HealthCare Association /CALM
23	Margie Plevak	Easy Living Estates
24	Christine A Klapak	PANPHA
25	/STAN UPOR	Easy Living Management Corp.
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
36		
37		
38		
39		
40		
41		
42		
43		

STORM WARNING

Times are tough in the nursing industry—and on course to get much worse by decade's end.



By Alan Nadler, Senior Editor

Under normal circumstances, if you called Claudia Arias a statistic, she'd be offended. But when it comes to being part of the nursing shortage, she's all too happy to be one of the numbers.

She worked for 18 years as a nursing assistant and a licensed practical nurse until quitting in 1993 for what she calls "an early retirement without benefits." She eventually re-enlisted in 1999 for another tour of duty. "You don't have to tell me there is a nursing shortage out there," Arias says. "I lived through one for years."

Agreement over a shortage of qualified nursing help is easy to find among the nursing industry's Big Four: the American Association of Colleges of Nursing (AACN), the American Nurses Association (ANA), the American Organization of Nurse Executives (AONE) and the National League for Nursing (NLN). Combined, these organizations represent nearly all of the nation's approximately 3 million registered and assistant nurses.

The consensus of nursing specialists is that things are quite bad now—and will get much worse unless action is taken. According to these four agencies, fewer nurses are entering the workforce, certain geographical areas suffer acute shortages, and nurses adequately prepared to meet certain areas of patient need in a changing health care environment are even harder to find.

"The nursing profession (in general) is one that is going into crisis," former American Nurses Association President Mary Foley says. "There's a growing realization that the supply of appropriately prepared nurses is inadequate to meet the needs of a diverse population—and that this shortfall will grow more serious over the next 20 years."

And as one moves down the nursing hierarchy, the problem becomes even more pronounced: Although licensed practicals, or licensed vocational nurses—the basic bedside care providers who do everything from taking temperatures to treating bedsores—are expected to be one of the fastest-growing occupations during the next decade, the Census Bureau also projects that it will have one of the highest turnover rates.

Georges C. Benjamin, MD, secretary of the Maryland Department of Health and Mental Hygiene, summed up the situation rather simply during a Senate subcommittee in February 2001: "There are three problems," he says. "Nurses are not coming into the profession. The ones who are there are not staying in, and those who are there are not happy."

Declining numbers

Experts agree that a nursing shortage exists and will worsen by the end of the decade due to increasing turnover and a growing patient base. In 2000, the Department of Health and Human Services (HHS) estimated the nation's supply of registered nurses at 1.89 million, while demand was estimated at 2 million—a shortage of about 110,000, or 6 percent.

That shortage is expected to double to 12 percent by 2010, more than triple to 20 percent by 2015 and eventually peak at 29 percent by 2020 unless action is taken, Health and Human Services Secretary Tommy G. Thompson says.

The problem, according to HHS analysts, is basic supply and demand. Demand for nurses in general will grow by 40 percent from 2002 to 2020, while the supply of new nurses is expected to grow by only 6 percent in that time.

The growth in demand stems from an expected 18 percent growth in population, a larger proportion of elderly in the population and medical advances that necessitate additional medical care for people, according to Thompson.

As a result, HHS projects that 44 states and the District of Columbia will face severe nursing shortages by 2020 (see "Looking and lacking," page 21). The government recently stepped into the fray, attempting to alleviate the situation with money (see "Returned dividends," page 26).

It's an obvious problem—but not an easy one to solve, says Foley.

"Market demand, combined with workplace issues such as workload, staffing, career prospects and pay are the primary reasons for nursing turnover," Foley says. "Unless these issues are addressed, efforts to increase the overall supply of nurses will not be successful."

The bottom line

Nursing salaries overall have remained stagnant in the past 10 years—a fact that does little to attract new recruits to the profession. "[Nurses'] actual earnings increased steadily from 1983 through 2000, but 'real' earnings—the money available after adjusting for inflation—have been flat since 1991," Thompson says. "On average, nurses have seen no increase in purchasing power during the past decade."

Thompson points out that nurses' salaries are actually behind those of another perceived low-income group, elementary school teachers, and falling further behind each survey period. In 1984, the elementary school teacher's average annual salary was about $25,000, about $4,400 more than the average nurse. In 2001, elementary school teachers made almost $54,800 annually, while nurses averaged $41,000.

Furthermore, much of a nurse's wage growth takes place early and tapers off with time, Thompson notes. A nurse with five years of experience typically makes about 15 percent to 17 percent more than when he or she entered the field, but only 1 percent to 3 percent less than nurses with 15 to 20 years' experience.

"As their potential for increased earnings diminishes over time, staff nurses may be motivated to leave patient care for additional education and/or other careers in nursing – or outside the profession," Thompson says.

Many of the higher-paying jobs are in hospitals. Long-term care facilities – the most-likely employment locale for lower-level nurses and assistants – usually pay less.

"Factor in taxes, and even these 'median' people are taking home only about $8 an hour," says Bob Whitehall, an economist with Chalayne & Ryman in Chicago. "Add inflation, and you've got virtually no gain during the decade."

Health industry experts add that the nursing profession offers the LVN/LPNs an unhappy paradox: They're health care providers who usually lack their own health benefits. Because their jobs often require much physical work, caregivers often become injured on the job and end up being forced to leave the profession, according to Patrick Brady, executive director of Citizens for Long Term Care, a Washington D.C.-based nursing advocacy group.

Shades of gray

Nurses in general are getting older—just like the people they take care of, according to private studies and census

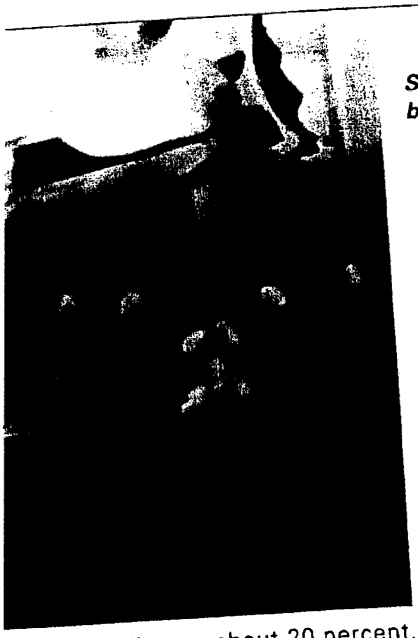
> "Nurses' **actual earnings increased** steadily from **1983 through 2000,** but **'real' earnings**—the money available after adjusting for inflation—**have been flat since 1991.**"
>
> *– Tommy G. Thompson,*
> Health and Human Services Secretary

data. Only 9 percent of regist
nurses in 2000 were less than 30
old—down from 25 percent in
and only about one-third of all regis
nurses were under age 40 in 2000
pared to nearly 50 percent in
according to the Department of
and Human Services. The averag
of the working registered nurs
43.3 in 2001; that age is expecte
50 by 2010.

In addition, those entering th
ing field are waiting longer. Hea
Human Services reports that st
of associate degree progran
largest source of new regi
nurses, are now about 33 ye
when they graduate, compare
average age of 28 in 1980.

This trend follows a genera
graphic shift, according to the
Bureau. The Bureau projects
cent decrease in the number
aged 25 to 34 in the labor fo
1995 to 2005, mostly due to t
ent sizes of generations. Unli
million-plus strong set of baby
the younger demographic
Generation X—is slightly mor
that size at 46 million.

Meanwhile, the population
to need nursing services wi
2000, about 35 million people
cent of the U.S. population,
or older. By 2030, the numbe



to 70 million, or about 20 percent, according to U.S. Census figures.

And, between 1995 and 2010, the number of people in the United States age 65 to 84 is expected to grow 13 percent, while the number of people age 85 or older will grow 56 percent – easily the fastest-growing segment of the population during the next 10 years.

While people age 85 or older make [illegible] percent of the population

> "It's an **obvious problem**—but not an easy **one to solve.**"
>
> 
>
> *– Mary Foley,*
> former American Nurses Association president

LOOKING & LACKING

States with current nursing shortages and those expected to have shortages by 2020, according to the U.S. Health Resources and Service Administration:

	2000	2005	2010	2015	2020
Alabama	n/a	- 5 %	- 6 %	- 11 %	- 18.7 %
Alaska	- 5 %	- 27 %	- 42 %	- 52 %	- 66.1 %
Arizona	- 17 %	- 21 %	- 25 %	- 32 %	- 39.2 %
Arkansas	- 8 %	- 10 %	- 14 %	- 24 %	- 34.2 %
California	- 8 %	- 10 %	- 21 %	- 34 %	- 46.8 %
Colorado	- 11 %	- 12 %	- 17 %	- 24 %	- 31.8 %
Connecticut	- 51 %	- 24 %	- 34 %	- 46 %	- 54.9 %
Delaware	- 11 %	- 29%	- 38 %	- 45 %	- 51.5 %
DC	n/a	- 14 %	- 21 %	- 28 %	- 34.3 %
Florida	n/a	- 7 %	- 12 %	- 22 %	- 33.1 %
Georgia	- 7 %	- 15 %	- 23 %	- 32 %	- 40.1 %
Hawaii	- 19 %	n/a	n/a	n/a	n/a
Idaho	n/a	- 20 %	- 37 %	- 50 %	- 59.1 %
Illinois	n/a	n/a	- 4 %	- 11 %	- 19.8 %
Indiana	- 10 %	- 12 %	- 17 %	- 23 %	- 31.5 %
Iowa	- 3.5 %	n/a	n/a	n/a	n/a
Kansas	n/a	n/a	n/a	n/a	n/a
Kentucky	n/a	n/a	n/a	n/a	n/a
Louisiana	n/a	n/a	n/a	- 6 %	- 16.8 %
Maine	- 12 %	- 9 %	- 23 %	- 22 %	- 30.8 %
Maryland	n/a	- 8 %	- 17 %	- 27 %	- 35.9 %
Massachusetts	- 11 %	- 7 %	- 12 %	- 21 %	- 29.4 %
Michigan	n/a	n/a	- 7 %	- 14 %	- 22.0 %
Minnesota	- 3.5 %	n/a	n/a	- 5 %	- 14.6 %
Mississippi	n/a	n/a	n/a	n/a	- 5.3 %
Missouri	- 8 %	- 8 %	- 15 %	- 18 %	- 25.2 %
Montana	n/a	n/a	n/a	- 13 %	- 25.1 %
Nebraska	- 5 %	- 9 %	- 14 %	- 22 %	- 30.2 %
Nevada	- 11 %	- 15 %	- 19 %	- 23 %	- 27.6 %
New Hampshire	- 10 %	- 7 %	- 10 %	- 19 %	- 27.0 %
New Jersey	- 13 %	- 19 %	- 26 %	- 34 %	- 43.0 %
New Mexico	- 7 %	- 25 %	- 36 %	- 47 %	- 56.3 %
New York	- 11 %	- 8 %	- 10 %	- 16 %	- 23.6 %
North Carolina	n/a	n/a	n/a	- 11 %	- 19.4 %
North Dakota	n/a	- 3.2 %	- 9 %	- 17 %	- 25.9 %
Ohio	- 6 %	n/a	n/a	n/a	n/a
Oklahoma	n/a	- 6 %	- 13 %	- 20 %	- 28.3 %
Oregon	- 3.8 %	- 11 %	- 22 %	- 35 %	- 46.2 %
Pennsylvania	- 8 %	- 9 %	- 14 %	- 22 %	- 29.8 %
Rhode Island	- 10 %	- 16 %	- 26 %	- 38 %	- 47.6 %
South Carolina	n/a	n/a	- 5 %	- 10 %	- 17.8 %
South Dakota	n/a	n/a	n/a	- 9 %	- 22.7 %
Tennessee	- 13 %	- 22 %	- 31 %	- 40 %	- 48.6 %
Texas	- 9 %	- 7 %	- 10 %	- 17 %	- 26.3 %
Utah	- 8 %	- 12 %	- 19 %	- 27 %	- 36.8 %
Vermont	n/a	n/a	n/a	n/a	n/a
Virginia	- 10 %	- 15 %	- 21 %	- 29 %	- 36.4 %
Washington	- 9 %	- 14 %	- 28 %	- 33 %	- 42.6 %
West Virginia	n/a	n/a	n/a	- 5 %	- 12.1 %
Wisconsin	n/a	n/a	n/a	- 3.4 %	- 13.8 %
Wyoming	n/a	- 30 %	- 45 %	- 56 %	- 63.3 %
Total U.S.	- 6.3 %	- 7 %	- 12 %	- 20 %	- 28.8 %

Source: Health Resources and Service Administration

in 2000, by 2050 they'll make up 5 percent of all Americans, Census projections show.

"The greatest per capita demand for health care, and thus the services of nurses, will quite naturally come from the very old—those 85 and over," Thompson says.

No longer on the frontlines

The end result of these factors? Nurses of all levels are working more hours because there is no one to take their place, with many suffering job burnout and leaving the profession at a time when they are needed the most.

Health and Human Services estimates that nearly 20 percent of those with licenses have left active nursing. About 70 percent of these persons are age 50 or older. Not much is known about this "now inactive" group, but many are probably still working—in another field.

Arias says she spent a year simply "taking it easy" before working part-time at a retail distribution outlet. "I needed to clear my head," she says. "I didn't want to have to think about changing bed pans or taking someone's blood pressure. I wanted something low stress."

But six years of no- or low-stress was enough, Arias says. She went back to nursing, although she now works part-time. "Honestly, I got bored," she remarks. "I was sick of (nursing), but for some odd reason I missed it. It wasn't for the money. It wasn't for the fringe benefits. I went back because I actually missed it."

Easy solutions?

While various nursing groups and government agencies agree that the nursing shortage problem must be addressed, they're not certain exactly how.

In 2001, the Tri-Council—an organization made up of members of AACN, ANA, AONE and NLN—began discussing ways to reverse the situation. In July, the American Academy of Nursing continued discussing the matter during an interdisciplinary conference in Washington, D.C. And in August, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, Ill., presented results of its roundtable study on the problem (see "No laughing matter," page 24).

Among the possible solutions:

* Use new technology to make everyday tasks easier for nurses, allowing them to make better use of their time and provide more quality patient care.

* Identify options available to nurses beyond the entry-level role, including faculty, researcher and administrator.

* Reach out to youth, ages 12 to 18, via counselors, youth organizations, schools and other outlets to promote recruitment of a younger, more diverse population of nursing students.

* Implement appropriate salary and benefit programs.

* Redesign work to enable an aging workforce to remain active in direct care roles.

Some states are taking action as well, hoping to reduce the severity of an expected shortage by planning ahead. In Arizona, Gov. Jane Dee Hull created a Nursing Shortage Task Force to develop ways of keeping an adequate supply o nurses in the state in coming years.

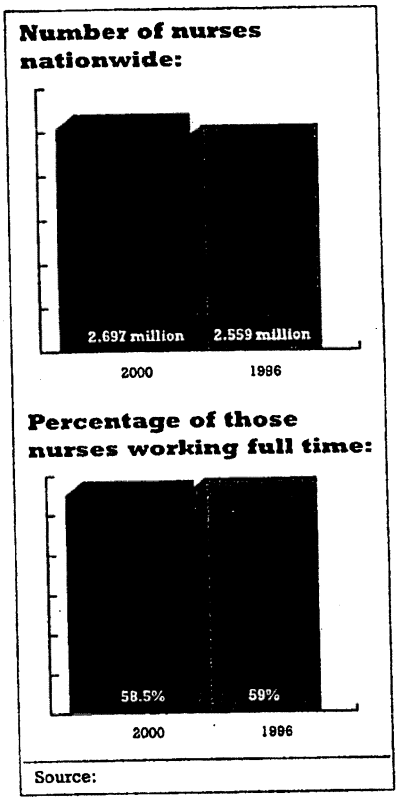
Arizona, one of the 10 most-popula states for persons over age 50 accord ing to the 2000 Census, already has quite a problem on its hands. In 2000 the U.S. Health Resources and Service Administration placed the state's nurs ing shortage at 17 percent, close to three times the national average. By 2020, that figure is expected to grow to more than 39 percent.

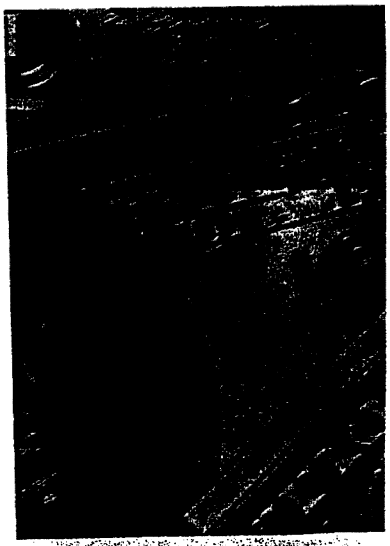
In addition, the turnover rate fo nurses in Arizona is higher than the national average, and the number o new registered nurses in Arizona has not grown during the past decade—while the state's population has risen by 30 percent, according to Hull.

"National analysts continue to talk about the potential for health crises due to the lack of nurses," Hull says. "The goal of this task force is to prevent such a crisis from happening in Arizona."

Task force members, who include members of health departments from Arizona counties, cities and universities, and medical staff from various public and private hospitals and assisted care facilities, must submit an interim report to the Governor by Dec. 15 and make final recommendations by Dec. 21, 2003.

Experts do offer one piece of good news: The shortage probably won't last forever. The labor force will begin to grow faster than the population by 2040, according to the Census. CLTC





NURSING FACTS

Where the demand will be

As the public ages, demand for nursing care will shift in coming years. Here's where nurses will be needed most from 2000 to 2020:

Year	Hospitals	Nursing Homes	Public Health	Ambulatory Care	Home Health	Occupational Health
2000	62.1 %	8.4 %	4.8 %	8 %	6.5 %	1 %
2005	62 %	9 %	4.4 %	7.8 %	7.1 %	1 %
2010	61.9 %	9.5 %	4 %	7.6 %	7.6 %	0.9 %
2015	62 %	9.9 %	3.6 %	7.3 %	8.2 %	0.9 %
2020	62 %	10.4 %	3.3 %	7 %	8.9 %	0.8 %

Source: Health Resources and Service Administration

Where the money isn't

Annual Salaries of Registered Nurses vs. 'Real' Earnings, 1984-2001

Year	Annual Salary	Real Earnings*
1984	$25,064	$22,063
1990	$29,588	$23,861
1995	$35,146	$23,701
2001	$41,060	$23,409

**Real Earnings reflects nurse salary equivalent after adjusting for inflation*

Source: Bureau of Labor Statistics

By the numbers

National supply and demand projection for full-time registered nurses, 2000-2020

Year	Supply	Demand	Percent Shortage
2000	1.889 million	2 million	- 6 %
2005	2.012 million	2.162 million	- 7 %
2010	2.069 million	2.345 million	- 12 %
2015	2.055 million	2.563 million	- 20 %
2020	2.002 million	2.81 million	- 29 %

Source: Health Resources and Service Administration

"R.N. Claudia Arias says she spent a year simply **"taking it easy"** before working part-time at a retail **distribution outlet.** "I needed to clear my head. **I didn't want to** have to think about **changing bed pans** or taking someone's blood pressure. **I wanted something low stress.**"

This study represents the cost as a consequence of regulation 2600.

The cost to the each resident would be $107,048.00 per year

The cost to the state would be $4.4 billon

This cost study was prepared using the following assumptions:

1 All cost was based on Easy Living Estates of Somerset.
A small rural town facility with about 30 residents

2 Salary and overhead
Administrator $45,000 + 32% for taxes, Workman's Comp., Unemployment, Etc. = $59,400.00 or $29.70 per hour
Average Labor $6.00 per hour + 32% = $7.92 per hour

3 Total staff 15 employees plus extra

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.20 (b) (7)	To take resident to the bank once a month Mileage 15 miles x .30 = $4.50 Administrator Labor 1 Hour $29.70 $29.70 x 10 residents x 12 months		$3,654.00		
2600.20 (b) (10)	To write and obtain signature at death Administrator Labor 2 hours x $29.70	$59.40			
2600.23 (2)	At hire and weekly 15 positions Administrator Labor 1 hour $29.70 15 x 29.70 x 52		$23,166.00		
2600.24 (1)	Securing Transportation Administrator Labor 15 minutes	$7.42			
2600.24 (2)	Shopping Administrator Labor 1 hour $29.70 Mileage 15 miles x .30 = $4.50	$34.20			
2600.24 (3)	Making Appointment Administrator Labor 15 minutes	$7.42			
	Keeping appointment Administrator Labor 1 hour $29.70 Mileage 15 miles x .30 = $4.50	$34.20			
2600.24 (6)	Correspondence Administrator Labor 20 minutes	$9.90			

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.25	Personal Hygiene		$21,681.00		
	Time needed to document				
	Direct Care Staff 15 min/day/resident				
	Staff wage $7.92				
	$1.98 x 365 x 30 residents				
2600.26	Resident Contract	$29.70			
	to Explain	once per contract			
	Admission Director Labor 30 Minutes				
	Witness Administrator 30 minutes				
2600.26 (a)	If the resident agrees	$14.85			
	Admission Director Labor 30 minutes	once per contract			
2600.26 (a) (3 & 4)	Itemize Charges	$59.40			
	Admission Director Labor 2 hours	once per contract each occurrence			
2600.26 (a) (6)	Detailed Refund Policy	$7.42			
	Admission Director Labor 15 minutes	once per contract			
2600.26(a) (10)	30 day advance letter		$325,215.00		
	Administrator labor 1 hour $29.70				
	This can change daily				
	$29.70 x 365 x 30 residents				
2600.26 (a) (11)	List of Services		$162,607.50		
	Admission Director Labor 30 minutes				
	This can change daily				
	$14.85 x 365 x 30 residents				

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.26 (a) (12)	Any Additional Services		$325,215.00		
	This is to detailed "any"				
	Manager 30 minutes				
	Admission Director 30 minutes				
	$29.70 x 365 x 30				
2600.26 (d)	Extra person for Saturday, Sunday, Holiday		$6,969.60		
	Sat & Sun 104 days x 8 hours = 832 hours				
	Holiday 6 days x 8 hours = 48 hours				
	880 hours x $7.92 = $6969.60 yearly				
2600.27 (a)	Quality Assessment & Management plan		$3,029.40		
	Manager Labor 30 minutes				
	Administrator Labor 1 hour				
	Manager x employees x months				
	$14.85 x 15 x 12 = $2673.00				
	Administrator x months				
	$29.70 x 12 = $356.40				
2600.27 (b) 5	Family council		$712.80		
	Manager 1 hour per month				
	$29.70 x 12				
	Administrator 1 hour per month				
	$29.70 x 12				
	Resident council		$712.80		
	Manager 1 hour per month				
	$29.70 x 12				
	Administrator 1 hour per month				
	$29.70 x 12				

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.31 (a)	Family, advocate Notice	**$89.10**			
	Admission Director 3 hours	once per resident			
2600.31 (b)	"in a language"	**$89.10**			
	Interpreter 1 hour $29.70	once per resident			
	Admission Director 1 hour $29.70				
	Manager 1 Hour $29.70				
2600.31 (d)	Signed Statement of rights	**$29.70**			
	Manager or Admission director 1 hour	once per resident			
2600.31 (g)	Complaint decision		**$92,664.00**		
	Administrator and Manager 1 hour				
	per resident per week				
	$59.40 x 30 x 52				
2600.32 (v)	Resident Right		**$37,315.20**		
	Contracted services				
	Administrator 8 hours per week				
	$29.70 x 8 x 52 = $12355.20				
	Lawyer 8 hours per week				
	$60.00 x 8 x 52 = $24960.00				
2600.32 (w)	Resident right to appeal		**$1,544.40**		
	Administrator 1 hour per week				
	$29.70 x 52				
2600.31 (x)	Bonding each employee		**$3,750.00**		
	15 employees				
2600.53 (a) (2)	Associate Degree		**$3,000.00**		
	Additonal Salary				

2600 Regulations Cost Study

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
					$7,000.00
2600.53 (d)	Administrator's responsibility		$7,000.00		
	Liability Insurance premium				
2600.54 (2)	Have a high school diploma or GED		$15,000.00		
	.50 per hour per employee per year				
	.50 x 2000 hours in a year x 15 employees				
2600.56 (a)	"each" mobile resident 50% cost of wages		$53,385.27		
	half needs less than 1 hour				
	half needs more than 1 hour				
	$80,886.78 (yearly wage cost) x 32% (cost				
	of taxes, Unemployment, etc) / 50%				
2600.56 (a)	immobile "special needs"		$53,385.27		
	50% cost of wages				
2600.56 (c)	Administrator designee		$138,600.00		
	7 days x 24 hour at $40,000/year				
	4.2 designee at $25,000/year				
	overhead 32% = $33,600.00				
2600.57 (b)	Administrator Training		$26,000.00		
	additional salary for administrator				
	additional salary for 4.2 designee				

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.57 (e)	Administrator 24 hours annual training		$16,251.84		
	18 hours additional				
	9-2 hour clases (including travel) = 36 hours				
	total 54 hours x $29.70 = $1603.80				
	Replacement administrator				
	32 hours x $29.70 = $950.40				
	Administrator designee				
	same training as administrator				
	4.2 x $2554.20				
	Cost of Class				
	Administrator 18 hours x $25.00 = $450.00				
	Designees 4.2 x 24 hours x $25.00 =$2520.00				
2600.57 (e) (1)	CPR & First Aid		$183.50		
	3 hour class + 2 hours travel = 5 hours				
	5 hours x $29.70 = $148.50				
	Cost of Class = $35.00				
2600.58 (a)	Prior to working with residents		$9,937.62		
	1 30 minutes				
	(I) 30 minutes				
	(ii) 15 minutes				
	(iii) 10 minutes				
	(iv) 10 minutes				
	(v) 30 minutes				
	(vi) 45 minutes				
	(vii) 5 minutes				
	2 15 minutes				
	3 10 minutes				
	4 15 minutes				
	5 30 minutes				
	total 21 hours				

2600 Regulations Cost Study

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
	21 hours x 56 employee = 1176 hours 1176 hours x $7.92 = $9313.92 Administrator 21 hours x $29.70 = $623.70				
2600.58 (c)	Training 24 hours x $7.92 = $190.08 $190.08 x 56 employees = $10,644.48		**$10,644.48**		
2600.58 (e)	24 hours annual training 24 hours x 30 employees x 720 hours Wages $7.92 + overtime $3.96 = $11.88 $11.88 x 720 = $8553.60		**$8,553.60**		
2600.59	Staff Training Plan 1 3 hours 2 5 hours 3 2 hours 4 8 hours 58 hours total by administrator 58 hours $29.70 = $1722.6o		**$1,722.60**		
2600.60	Individual staff training plan 4 hours 1 2 hours 2 16 hours 3 2 hours 24 hours by administrator 24 x $29.70 = $712.80		**$712.80**		

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.85 (d)	Trash - covered		$86,724.00		
	1 hour per room per day = 30 hours labor $7.92 per hour = $237.60 $237.60 x 365 days = $86,724.00				
2600.89	Water		$475.20		
	$150 each 3 months + labor Test and Delivery = 4 hours each time $150.00 x 4 = $600.00 per year 16 hours x $29.70 = $475.20				
2600.90	Communication System		$1,200.00		
	$100.00 month x 12 months				
2600.98 (c)	Indoor Activity space		$28,416.96		
	24 hours per week 24 x $7.92 employee = $190.08 12 x $29.70 administrator = $356.40 $546.48 x 52 weeks = $28,416.96				
2600.101 (l)	Resident's Privacy - curtains around beds	$15,000.00			
	$500.00 per room x 30				
2600.101 (k) (1)	Bed description	$6,000.00			
	$200.00 per bed x 30				
2600.101 (r)	Lift chair as a comfortable chair	$75,500.00			
	$2500.00 x 30				
2600.102 (g)	Bathrooms - toiletry items for everyone	$3,000.00			
	$100.00 x 30 residents				

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.102 (j)	Toiletry and linens $15.00 x 30 residents	$450.00			
2600.103 (b)	Sanitzed after each meal 3 hours per meal = 9 hours per day 9 $ $7.92 = $71.28 per day $71.28 x 365 days = $26,017.20		$26,017.20		
2600.103 (e)	Food labeled and rotated 2 hours per week 2 x $7.92 x 52 weeks = $823.68		$823.68		
2600.105 (g)	Laundry - lint removal 15 minutes x 24 hours x 365 days = 2190 hours 2190 hours x $7.92 = $17344.80		$17,344.80		
2600.107 (b)	Written emergency procedures - annually 8 hours x $29.70 administrator = $237.60 Saftey inspector $200.00 per year		$437.60		
2600.126	Furnace inspection		$200.00		
2600.130 (f)	Written record smoke detectors / alarms $450.00 per month		$5,400.00		
2600.130 (i)	Fire alarm system for 5 immobile new panel cost	$6,000.00			
2600.142 (a)	resident support plan 1 hour x 30 residents x $29.70 administrator		$10,692.00		

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.142 (b)	Train resident about needs				
	1 hour x 30 residents x $29.70 administrator	**$891.00**			
2600.161 (f)	Therapeutic diets		**$34,689.60**		
	This will double cost of kitchen				
	12 hours per day x $7.92 x 365 days				
2600.161 (g)	Drink every 2 hours		**$45,990.00**		
	Cost of beverage .35 x every 2hours x				
	30 residents x 365 days				
2600.163 (d)	Staff with infected wound, etc.		**$2,468.96**		
	Will raise kitchen cost 10%				
	12 hours x $7.92 x 365 days / 10%				
2600.181 (e)	Resident must know medication		**$874,177.92**		
	4.2 RN's x 24 hours a day x $23.76 X 365				
2600.181 (e)	53,926 x $227 per day x 365 days			**$4,468,038,730.00**	
	Cost to state if all PCH homes close				
	See comment at the end.				
2600.182 (a)	Medication Storage - original container		**$8,672.40**		
	1 hour x 3 times a day x 365 days				
	$7.92 x 3 x 365 = $8672.40				
2600.184 (b) 1	Documentation		**$13,008.60**		
	1.5 hours x 3 times a day x 365 days				
	$76.92 x 1.5 x 3 x 365 = $13,008.60				
2600.201 (b)	Quality Improvement program		**$46,332.00**		
	Administrator				
	1 hour x $29.70 x 30 residents x 52 weeks				

Regulation	Calculation	Each Time Cost	Yearly Cost	Cost to State	Additional Insurance
2600.223	Description of services		$650,430.00		
	Administrator 2 hours per resident per day				
	2 x $29.70 x 30 x 365				
2600.225 (d) (3&4)	Assessment - Hospital Discharge / Agency		$5,346.00		
	Administrator 1 hour x 6 times per year				
	$29.70 x 6 x 30 residents				
2600.226	Development of support plan				
	Cost was addressed in 2600.223				
	Total Cost	**Each Time Cost** $107,312.81 varies	**Yearly Cost Average facility** $3,211,460.60	**Cost to State** $4,468,038,730.00	**Additional Insurance** $7,000.00

At an average facility, the present private pay is $55.28 per day or $20,177.00 per year.
This new regulation as proposed will cost $107,048.00 per year per resident or $293.28 per day.
Plus the items listed as "each time"
Cureently Personal Care Homes, cost to the public is 1/2 the amount of Nursing Homes.
With this new regulation 2600, Personal Care Homes will cost twice as much.

"NO COST TO THE PUBLIC"

This was the statement made by Feather Houstoun, Secretary of Public Welfare, on page 12 of her letter.

There are 18 policy and procedure manuals and 59 separate documentations that are being required.
Along with the additional calculations that will be needed from the support plan for staffing requirements,
the DPW will have to double the inspectors for Personal Care Homes.
With approximately 64 inspectors statewide at an annual salary of $35,000.00 + 32% = $46,200.00

This would cost the State, per year **$2,956,800.00**

If the 2600 regulations are implemented, PCH homes will close.
This will force the state to transfer the residents to skilled nursing facilities.
May 2002 census of PCH Residents 53,926
53,926 x $227 per day x 365 days

This would cost the State, per year **$4,468,038,730.00**

The cost to implement 2600.181 (e), alone, will cause PCH homesto close.
This is a stupid and malicious as a regulation can get.
The intent of just this one regulations is to close the door on Personal Care Homes.
I am an administrator but I can't recall all what is required to meet the requirements for self-administration of medicine.
Therefore, most likely no PCH/AL resident can, that is why they consented to be a resident in the first place.
They will not quality for residency, therefore they will need to be transferred to a skilled nursing facility
at a cost to the state, because Personal Care Homes will be out of business.

As a consequence of the new regulation, no SSI resident will be accepted at PCH/AL facilities.
The state pays $29.00 per day, the fair SSI rate should be $51.98.

Current SSI Population in State	10,529.00
Nursing home Daily rate	$227.00

10529.00 x $227.00 x 365 days

This would cost the State, per year **$872,380,295.00**

§2600.3. Inspections and licenses or certificates of compliance.

(a) An authorized agent of the Department shall conduct on-site inspections of personal care homes.

(b) A certificate of compliance shall be issued to the legal entity by the Department if, after an investigation by an authorized agent of the Department, the requirements for a certificate of compliance are met.

(c) The personal care home shall post the current certificate of compliance in a public place in the personal care home.

§2600.4. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Abuse - One or more of the following acts:

(i) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish,

2600.3 Inspections and licenses or certificates of compliance

(b) If a plan of action is agreed upon and completed then a certificate of compliance should be issued to the legal entity.

2600.4 Definitions

This section has expanded with 11 new definitions when compared to the current CHAPTER 2620.
A significant change is that PCH staff is now clearly categorized as ancillary or direct care staff. We like this.

The second noticeable change is in the nomenclature of: 2620.32 "personal hygiene" being converted to 2600 ADL, and
2620.33 "tasks of daily living" being converted to 2600 IADL.
The conversions are clearly from the influence of the nursing homes with the medical background. Philosophically, we disapprove of the medical-model association.
The change of terminology has not been consistent throughout the proposed 2600 regulations.

We recommend "cleaning up" the final form regulation: either use personal hygiene/tasks of daily living OR ADL/IADL

Agent - A person authorized by the Department or other State Agency to enter, visit, inspect, or conduct an investigation of a personal care home.

Appropriate assessment agency or agent - An organization serving the aged or disabled population, such as a county mental health/mental retardation agency, a drug and alcohol agency, an area agency on aging or another human service agency, or an individual in an occupation maintaining contact with the aged and disabled, such as medicine, nursing or rehabilitative therapies.

Commercial boarding home - A type of residential living facility providing only food and shelter, or other services normally provided by a hotel, for payment, for persons who require no services beyond food, shelter and other services usually found in hotel or apartment rental.

Complementary and alternative medications - Practices, substances, and ideas used to prevent or treat illness or promote health and well-being outside the realm of modern conventional medicine. Alternative medicine is used alone or instead of conventional medicine. Complementary medicine is used along with or in addition to conventional medicine.

Complaint - A written or verbal criticism, dispute, or objection presented by or on behalf of a resident regarding the care, operations, or management policies of a personal care home.

Department - The Department of Public Welfare of the Commonwealth.

Commercial boarding home
We prefer the verbage from Chapter 2600 which adds
"...to adults who are unrelated to the owner..."

(b) Personal care homes shall be inspected as often as required by 62 P.S. §211 (l), and more often as necessary. After initial approval, homes need not be visited or inspected annually except that the Department will schedule inspections in accordance with a plan that provides for the coverage of at least seventy-five percent of the licensed homes every two years and all homes shall be inspected at least once every three years.

§2600.12. Appeals.

Appeals related to the licensure or approval of the home shall be made in accordance with 1 Pa. Code Chapters 31, 33 and 35 (relating to General Rules of Administrative Practice and Procedure).

§2600.13. Maximum capacity.

(a) The licensed capacity is the total number of residents who are permitted to reside in the personal care section of the home at any time. A request to increase the capacity shall be submitted to the Department and other applicable authorities and approved prior to the admission of additional residents. The licensed capacity is limited by physical plant space, zoning, and other applicable statutes and regulations.

(b) The maximum capacity specified on the license or certificate of compliance shall not be exceeded.

2600.11 Procedural requirements for Licensure or Approval of homes.
(b) A home may not be inspected for three years and many problems could occur during this period of time which will go unfounded. Why are we being over regulated and under inspected.

Less inspections would NOT ensure the health, safety, and welfare of our residents. We feel strongly that this could have an adverse effect.

Our recommendation: To keep Chapter 2620, but increase the inspections to every 6 months.

This not only has a direct impact on the health, safety, and welfare of our residents, but it also has an economical impact on the Commonwealth. More inspectors will be needed to review the mountains of paperwork that these regulations will require. We are unable to give an estimate of what this will cost the Commonwealth, but feel that it would be in excess of $160,000 per year.

§2600.5. Access requirements.

(a) The department will have the right to enter, visit, and inspect any home licensed or requiring a license and shall have full and free access to the records of the home and to the residents therein and full opportunity to interview, inspect, or examine such residents.

(b) The administrator and staff shall provide, upon request, immediate access to the home, the residents, and the residents' records to agents of the Department or other State Agencies, representatives of the Department of Aging's Older Adults Protective Services Program, and the Long-Term Ombudsman Program.

(c) The administrator shall permit a resident's relatives, community service organizations and representatives of community legal services programs to have access to the home during the home's visitation hours or by appointment for the purpose of visiting, or assisting or informing the residents of the availability of services and assistance.

GENERAL REQUIREMENTS

§2600.11. Procedural requirements for Licensure or Approval of homes.

(a) Except for §§20.31 and 20.32, the requirements of Chapter 20 (relating to licensure or approval of facilities and agencies) shall apply to all homes.

2600.5 Access requirements.

(a) The word *shall* has been replaced with this word *will*. Why do we need such strong language and it is not consistent throughout the document.

There is no time frame explaining when the department will have access. Unless the department has reasonable question relating to a violation then access should be during normal business hours.

(b) The staff should not be permitted to have access to all records including personnel files as this information is confidential. The staff will have access about the health of the residents, insurance information, emergency contact, next of kin, and power of attorney but not necessarily financial records of the resident.

Please be more specific about who is meant by *other State Agencies;* this could force a home to give information about a resident to DEP, State Police, Emergency Management, Liquor Control Broad, etc. so anyone working for the state would be able access the facility and obtain any information.

2600.11 Procedural requirements for Licensure or Approval of homes.

(a) The annual inspections should remain as announced inspections because certain information including personnel records, payroll, or income reports are confidential and not all employees will have this information.

(c) The home shall immediately report the incident to the personal care home regional field licensing office or their designee in a manner designated by the Department. Abuse reporting shall also follow the guidelines outlined in §2600.15 (relating to abuse reporting covered by statute).

(d) A preliminary written notification of incidents, on a form prescribed by the Department, shall be sent to the personal care home regional field licensing office within 5 days of the occurrence. Abuse reporting shall also follow the requirements in §2600.15 (relating to abuse reporting covered by statute).

(e) The home shall submit a final report, on a form prescribed by the Department, to the regional field licensing office immediately following the conclusion of the investigation.

(f) The home shall keep a copy of the incident report on file as required by §2600.243 (b) (relating to record retention and disposal).

§2600.17. Confidentiality of records.

Resident records shall be confidential, and, except in emergencies, shall not be open to anyone other than the resident, the resident's designee, if any, agents of the Department and the long-term care ombudsman unless the resident, or his designee, consents, or a court orders disclosure.

§2600.18. Applicable health and safety laws.

2600.16 Reportable incidents

(c) The administrator, not the home, will be responsible for immediately reporting an incident.

(f) There is a reference to 2600.243 (b); however, this does not exist in this document.

This regulation generates excessive paperwork in that it requires (c)immediate report, (d)preliminary report, and (e) a final report for each incident.

Our suggestion: to use the exact verbage from 2620.63 (a) and (b). An immediate telephone call to notify the Dept. followed by a final report within 5 days from the administrator or his designee.
The other 2 reports simply take away from resident care.

There are also some issues created by (f), in that incident reports are NEVER kept on a resident's chart. A narrative note is made on the chart. This is not a good protacal and is Not one which would be found in hospitals or nursing homes.

2600.17 Confidentiality of records

The resident records should not be limited to the resident, their family, a designee, long-term care ombudsman, and the Department or in the event of an emergency. The resident records should also be available for home health personnel and doctors.

residents of the home to allow the residents the opportunity to submit comments to the Department. The home shall also provide the residents with the name, address, and phone number of the personal care home field licensing field office to submit their comments. The home shall interview affected residents as appropriate.

(d) A home seeking a waiver shall submit a written request for a waiver to the appropriate personal care home licensing field office. A waiver granted by the Department shall be in writing, shall be part of the home's permanent record and shall be maintained on file in the home's records.

(e) The home shall notify the residents of the approval or denial of the waiver request. A copy of the waiver request shall be posted in a conspicuous public place within the home.

(f) Waivers are subject to a periodic review by the Department to determine whether acceptable conditions exist for renewal of the waiver. The Department reserves the right to revoke the waiver if the conditions required by the waiver are not met.

(g) A structural waiver will not be granted to a new facility, new construction, or renovations begun after the effective date of this chapter. Upon request, the Department will review building plans to assure compliance with the requirements of this chapter.

§2600.20. Resident funds.

(g)Is a structural waiver within the realm of DPW? We believe that it is an issue for L&I. According to IRRC's Appendix B Regulatory Review Act Criteria 3.i."Possible conflict with or duplication of statutes or existing regulations:"....we ask that this be studied. Does it belong to DPW or L&I?

Perhaps the more important issue to be discussed revolves around existing homes/buildings. In this set of proposed regulations there is a Grandfather in " of staff, but there is not any verbage for the "grandfather in" of currently licensed buildings. Throughout the Commonwealth there are homes which have been licensed for many years, that will not be able to structurally comply with the mandated requirements of Chapter 2600. Some changes may not be economically feasible, and other changes may not be structurally possible due to a variety of factors such as zoning etc.

EXISTING PCH MUST HAVE ~~THEIR BUILDINGS~~ GRANDFATHERED_IN. STRUCTURAL WAIVERS MUST BE CONSIDERED, AND THEY SHOULD BE UNCONDITIONAL.

Our residents consider the PCH to be their HOME. Some have lived at the same location for many years. It would create an undue and emotional hardship on our residents and their families if they would have to be relocated from the homes that they love because waivers will not be granted to the building. THIS IS UNFAIR.

We ask that this point be taken into consideration as it is an essential point to preserve the small, independent homes. Perhaps a study should be done to evaluate the number of legitimately licensed homes across the state that will be forced to close, as well as the number of residents to be relocated. The study should also include the status of the homes mortgages and any other monies lost secondary to home closure due to no waivers.

(4) The resident shall be given funds requested within 24 hours if available, and immediately if the request is for $10 or less. This service shall be offered on a daily basis.

(5) The home shall obtain a written receipt from the resident for cash disbursements.

(6) There may be no commingling of the resident's personal needs allowance with the home's or staff person's funds or the home's operating accounts.

(7) If a home is holding funds in excess of $200 for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local federally-insured financial institution. This does not include security deposits.

(8) The owners of the home, its administrators, and employees are prohibited from being assigned power of attorney or guardianship of a resident.

(9) The home shall give the resident an annual written account of financial transactions made on the resident's behalf. The home shall provide the resident the opportunity to review his own financial record upon request during normal working hours. A copy shall be placed in the resident's record.

2600.20 Resident funds

(4) It may not be possible to access funds within 24 hours due to banking holidays, week-ends, and business hours. It is reasonable if the request is made during normal business days/hours and without holiday disruptions.

If multiple residents request $10.00 within the same time frame a home may be responsible for having hundreds of dollars in cash.

It is not acceptable to require that this service be offered on a daily basis. Holidays and week-ends should be excluded because of banking accessibility.

(9) The residents financial records and/or banking statements should not be part of the resident record for all staff to access. The resident should have the right to confidential financial information.

§2600.23. Personnel Management.

The home shall:

(1) Establish a work schedule and maintain copies for a year or until all litigation or audits are resolved, whichever is later.

(2) Establish and maintain written job descriptions for all positions that include:

(i) Job title.

(ii) Tasks, responsibilities, and essential functions of the job.

(iii) Qualifications.

(3) Provide each staff member with a copy of his job description at the time of hire and whenever the job description is changed. This shall be documented.

§2600.24. Tasks of daily living.

A home shall provide residents with assistance with tasks of daily living as indicated in their support plan and assessment, including, but not limited to, one or more of the following:

2600.23 Personnel Management

This entire section should be deleted because Labor Laws require this information. Why are you regulating something that is already regulated ?

The term "tasks of daily living is from our current Chapter 2620.33. However, in Chapter 2600 the name has been changed to IADL, which is a medical terminology.

For the sake of clarity the term should be consistent throughout this document.Since this Chapter chapter changed the name, this would be more appropriately labeled IADL (Instrumental Activities of Daily Living).

Assistance Act (72 P.S. §§ 4751-1—4751-12). If the PCH will be assisting the resident to manage a portion of the rent rebate, the requirements of §2600.21 (relating to resident funds) shall apply. There shall be no charge for filling out this paperwork.

(16) The resident, or his designee, shall have the right to rescind the contract for up to 72 hours after the initial dated signature of the contract. Rescission of the contract shall be in writing addressed to the home.

(b) The home shall not require or permit a resident to assign assets to the home in return for a life care contract/guarantee. Continuing care communities that have obtained a Certificate of Authority from the Insurance Department are required to provide a copy of the Certificate to the Department and will then be exempt from this requirement.

(c) A copy of the signed admission contract shall be given to the resident and a copy shall be filed in the resident's record.

(d) All service needs addressed in the resident's support plan shall be available to the resident 365 days a year.

§2600.27. Quality management.

(a) The homes shall establish and implement quality assessment and management plans.

2600.26 Resident-home contract: information on resident rights.

(16) The right to rescind the contract may put the home in a landlord-tenant situation and those laws would be applicable. This is not appropriate for personal care homes.

(c) Please add the word *payee*.

(d) Please delete this statement not all services are available 365 days a year such as hair style.

2600.27 Quality management

This work will require a whole department. Please delete the entire section.

While this section may be appropriate for very large "Walmart" type facilities, it is NOT suited for the smaller PCH. There has been an underlying feeling that these regulations are an attempt to annihilate the small business. This section is one that supports that theory.

In Westmoreland County there are 84 PCH according to the Sept.2002 DPW statistics. Only 17 of those listed have more than 51 beds, with only 5 being larger than 101 beds. This profession is dominated by the small homes, of which this section would not be appropriate.

(b) At minimum, the following shall be addressed in the plan review:

(1) Incident reports.

(2) Complaint procedures.

(3) Staff training.

(4) Monitoring licensing data and plans of correction, if applicable.

(5) Resident or family councils, or both.

(c) If the home fails to establish and implement quality assessment and management plans, the Department reserves the right to create the criteria that the home will utilize in establishing those plans.

§2600.28. SSI recipients.

(a) For a resident eligible for Supplemental Security Income (SSI) benefits, the home charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

(vi) Smoke detectors and fire alarms.

(vii)Phone use and notification of the local fire or police departments, or both.

(2) Resident rights.

(3) Emergency medical plan.

(4) Personnel policies and procedures.

(5) General operation of the home.

(b) Ancillary staff shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

(c) Training of direct care staff hired after the effective date of this regulation shall include a demonstration of job duties, followed by guided practice, then proven competency before newly-hired direct care staff may provide unsupervised direct care in any particular area. Prior to direct contact with residents, all direct care staff shall successfully complete and pass the following competency-based training including, but not be limited to the following specific job duties and responsibilities:

(1) Resident care.

2600.58 Staff training and orientation.

(b) and (d). We agree with these two items relating to orientation and training of ancillary staff. They represent excellent reasoning with a broad, non-limiting scope. This is a functional regulation.

(c) There are actually 4 strong components to our opposition for this section.

First- the organization and technical writing is poor and should not be accepted as a state regulation. On the technical writing (2)ADL's
(3)...and personal hygiene
(5)Personal care services
are all redundant terms, Under the new medical terms which these these proposed regulations have adopted, of ADL and IADL, the (2)ADL's is sufficient and complete. It is also consistent with 2600.4 Definition of ADL.

(3) Medication procedures,medical terminology... This should be seperated into two categories.
Ex: (3)Medications
(4)Medical terminology

Also (3) and (13) are redundant. The (3)Medications should include (13).

(13)...and use of universal precautions. This should be a seperate category. The term universal precaution has been changed to "standard precaution" by the medical world and OSHA.The updated terminology would be more appropriate for regulations written in 2002/3

We also find it hard to believe that the topic of body mechanics was not listed. It is the No.1 reason for workman's compensation and cause of missed work. Back-injury needs to be addressed!

The above items demonstrates how this section was so poorly written.

the required 40-hour PCH administrators training, and retake the competency test, until a passing grade is achieved.

(b) A record of training including the person trained, date, source, content, length of each course and copies of any certificates received, shall be kept by the home.

§2600.58. Staff training and orientation.

(a) Prior to working with residents, all staff including temporary staff, part-time staff, and volunteers shall have an orientation that includes the following:

(1) General fire safety including:

(i) Evacuation procedures.

(ii) Responsibilities during fire drills.

(iii) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

(iv) Smoking safety procedures and location of smoking areas, if applicable.

(v) The placement and use of fire extinguishers.

2600.58 Staff training and orientation.
(a) Actually we agree that this item is good. It is a basic issue for the health and safety of our residents.

However, we do feel that the work "volunteer" should be deleted, or clarified. Most Volunteers are guests of the home and are performing a social function. Training should not be required.

If a volunteer was giving hands on care;on a regular basis, then training may be appropriate. For example: someone that came to the home everyday to help feed.

It is extreme that a volunteer would need to be familiar with (4)personnel policies and procedures, and (5) general operation of the home.

(5) Staff supervision, budgeting, financial record keeping and training, which shall include but not be limited to:

(i) Writing, completing and implementing pre-admission screening tools, initial assessments, annual assessments, and support plans.

(ii) Resident-home contracts.

(iii) Development of orientation and training guidelines for staff.

(6) Local, State and Federal laws and regulations pertaining to the operation of a home.

(7) Nutrition, food handling and sanitation.

(8) Recreation.

(9) Mental illness and gerontology, which shall include, but not be limited to:

(i) Resident rights.

(ii) Care for persons with dementia and cognitive impairments.

(iii) Care for persons with mental retardation.

The outline for this section was poorly organized, and at the very least needs to be revised. The constructive criticism for this section includes:
(2)Personal care needs....the terminology in this set of proposed regulations was changed to ADL. Terminology, as defined in the 2600.4 Definitions needs to be consistent.

(4)..."and personal hygiene!... this would be part of (2). This phrase doesn't belong here.
(4)(iii)Infection control"....also doesn't belong here. Would be best addressed above in (2).

(4) Medications and medical terminology should be two seperate categories.

Also, if you add up the estimated time for 1-11, it exceeds 24 hours. We counted 29 hours.

We also feel that it is NOT necessary to repeat all these courses ANNUALLY. Most of these would be sufficient to take 1 time, with a possible update if the administrator thought it was indicated.

Training items 5 and 11 are the same.Delete one.

(b) Prior to licensure of a home, the legal entity shall appoint an administrator who has successfully completed and passed a Department-approved competency-based training that includes 60 hours of Department-approved competency-based training, and has successfully completed and passed 80 hours of competency-based internship in a licensed home under the supervision of a Department-trained administrator.

(c) The 60 hours of Department-approved competency-based training shall include, but not be limited to:

(1) Fire prevention and emergency planning.

(2) First aid training, medications, medical terminology and personal hygiene, which shall include, but not be limited to:

(i) Medication procedures.

(ii) Cardio-pulmonary resuscitation (CPR) certification.

(iii) Obstructed airway techniques certification.

(3) Local, State and Federal laws and regulations pertaining to the operation of a home.

(4) Nutrition, food handling and sanitation.

2600.57 Administrator training and orientation

(b) Where did the 80-hours of internship come, who is going to accept the intern, who is going to pay the wages for the intern and the wages for the administrator supervising the intern, who is going to be qualified to supervise the intern, who will assume the liability, who will be doing the competency based testing ????

Actually we agree and support the idea of higher training. We feel that 2600.57 will raise the standards, and ultimately improve the quality of care for our residents. We like the 60 hours of training with competency testing and the internship program.

We feel that this higher level of training negates the 4 qualifications of administrators.

(4) Be free from a medical condition, including drug or alcohol addiction that would limit the direct care staff from providing necessary personal care services with reasonable skill and safety.

§2600.55. Exceptions for staff qualifications.

(a) The staff qualification requirements for administrator and direct care staff shall not apply to persons hired or promoted to the specified positions prior to the effective date of this chapter as long as the home maintains a current license.

(b) A staff person who transfers to another licensed home, with no more than a one-year break in service, may work in the same capacity as long as he meets the qualifications outlined in subsection (a).

(c) Notwithstanding §2600.54, a 16 or 17 year old may be employed as a staff person at a home, but shall not perform tasks related to medication administration, and the incontinence care or bathing of persons of the opposite sex.

§2600.56. Staffing.

(a) A home shall employ a sufficient number of trained staff to ensure the daily provision of the aggregate total of personal care service hours required by the support plans for all residents in the facility. At minimum, each mobile resident shall receive an average of one hour of

2600.54 Staff titles and qualifications for direct care staff

2600.55 Exceptions for staff qualifications

(b) There is no other profession that limits a break in service, why personal care home business? Requiring that CEU's must be maintained during the break in service may be more acceptable.

(c) A staff person age 16 or 17 that has been trained should not be limited bathing only same sex residents and incontinence care may be toileting every two hours. Most baby sitting courses certify people that are age 14 which consist of diapering a baby, why would a person age 16 be unable to care for the elderly?

2600.56 Staffing

(a) Please clarify hours because as this paragraph reads *each resident shall receive one hour of personal care hours.* This paragraph should read total hours during a certain period of time depending on the number of residents and their needs.

(l) A resident shall have the right to purchase, receive, and use personal property.

(m) A resident shall have the right to leave and return to the home at reasonable times consistent with the home's rules.

(n) A resident shall have the right to request and receive assistance, from the home, in relocating to another facility.

(o) A resident shall be free to associate and communicate with others privately.

(p) A resident shall be free from restraints.

(q) A resident shall be compensated in accordance with State and Federal labor statutes for labor performed on behalf of the home. Residents shall perform personal housekeeping tasks related directly to the resident's personal space but shall not perform tasks in lieu of a staff person who is otherwise required to perform these tasks.

(r) A resident, the resident's family, advocates, if any, community service organizations, and legal representatives shall have access to the home during visitation hours or by appointment. A resident shall have the right to receive visitors for a minimum of 8 hours daily, 7 days per week.

(s) A resident shall have the right to privacy of self and possessions.

2600.32 Specific rights

(1) Please add *and use consistent with home rules.* Examples would be the use of matches or over the counter drugs (OTC)

(n) The home should not be responsible for providing assistance with relocation. The home should be expected to provide the resources for relocation but not necessarily the actual assistance of relocation such as tours, moving, etc.

This sentence would be acceptable if the three words ",from the home," were deleted.

(2) ADL's.

(3) Medication procedures, medical terminology and personal hygiene.

(4) Care of residents with mental illness and cognitive impairments.

(5) Personal care services.

(6) Implementation of the initial assessment, annual assessment, and support plan.

(7) Nutrition, food handling and sanitation.

(8) Recreation.

(9) Gerontology.

(10)Staff supervision, if applicable.

(11)Needs of residents with special emphasis on the residents being served in the home.

(12)Safety management and prevention.

2600.58 Staff training and orientation.

Second- this is excessive training. Although the nature of the list is fair in theory, it is not practical. It would require 20 hours to accomplish this list of training

Third- it is not economically feasible to do this. Please cross reference to cost study written in section (f).

Fourth- Training "PRIOR to direct contact with residents" is not reasonable, for two reasons. There is such a high turnover of staff. Many new hirees would not get pass the class-work. And, direct care staff must have hands-on training to clearly understand the job function and responsibility.

(13)Use of medications, purposes and side effects of medications, and use of universal precautions.

(14)Policies and procedures of the home, including but not limited to:

(i) Reportable incidents.

(ii) Implementation of support plans.

(d) Ancillary staff shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity. Ancillary staff shall receive training specific to their job function.

(e) Direct care home staff shall have at least 24 hours of annual training relating to their job duties. Staff orientation shall be included in the 24 hours of training for the first year of employment. On the job training for direct care staff may count for 12 out of the 24 training hours required annually.

(f) Training topics for the required annual training for direct care staff shall include but are not limited to:

(1) Current training in first aid, certification in obstructed airway techniques, and certification in cardio-pulmonary resuscitation that is appropriate for the residents

2600.58 Staff training and orientation.

(e) There are 3 components to our opposition with this requirement. First- WHY should the annual training for direct care staff of a PCH EXCEED the annual training requirements for a CNA in more acute health care settings such as hospitals, homecare, and nursing homes. CNA's in those settings are required to have 8-12 hrs/yr. This regulation is not reasonable.

Secondly- The list for annual training in (f)(1-8) and(g)(1-7) add up to 26-29 hrs. of annual mandated training for a 24hr. requirement.Some of the topics may not be appropriate for all direct care staff. The list is too rigid, too restrictive, too specific, and does not leave any room for any stimulating new topics.

Third- The economic impact of this requirement was not taken into consideration. We certainly do not have the economic backing that hospitals and skilled facilities have. Many homes, especially those that cater to the SSI population, are running on a near $00.00 budget.

In discussing the actual cost to the PCH, three factors must be considered. (1)The actual cost of the training class. An estimate is $10/hr. (2)The wages of the staff person taking the class. The lowest estimate would be $6.00/hr plus 35%for taxes and benefits. However this could be as high as $30/hr if the staff was an R.N. or Adm.designee. (3)The cost of another staff covering the floor during the training time.

For a comprehensive analysis, please refer to our addendum in the back titled "2600 Regulations Cost Study".

Here's how the (e)requirement of 24 hrs./yr. adds up For every direct care staff:

24 hrs. of training/yr X $10/hr. for class=	$ 240.00/yr.
$6/hr plus 35%= $8.10/hr X 24hr./yr =	$ 194.40/yr.
must incur this cost X2 for floor coverage=	$ 194.40/yr.
	$ 628.80/yr

for each staff.

served, and shall be completed by an individual certified as a trainer by a hospital or other recognized health care organization. Registered nurses, licensed practical nurses, certified registered nurse practitioners, emergency medical technicians, paramedics, physician's assistants, or licensed physicians are exempt from the requirement for annual first aid training.

(2) Medication self-administration training.

(3) Understanding, locating, and implementing preadmission screening tools, initial assessments, annual assessments, and support plans.

(4) Care for persons with dementia and cognitive impairments.

(5) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.

(6) Personal care service needs of the resident.

(7) Safe management technique training, which shall include, but not be limited to, positive interventions such as:

(i) Improving communications.

2800.58 Staff training and orientation. Continued:

For every Administrator, adm.designee., or R.N.:
24 hrs. of training/yr X $10/hr.for class=**$240.00/yr.**
$30/hr plus 35% = $40.50/hr X 24 hrs/yr =**$972.00/yr.**
must incur this cost X2 for coverage =**$972.00/yr.**
$2184.00/yr.

Keep in mind that for argument purpose we chose the lowest figures to work with.of $6/hr. when more realistically it would be $8/hr. + 35% ($10.80) which gives $259.20/yr (instead of $194.4).

For a small home of 8 beds...3 employees would cost **$1886.40/yr, for annual training.** Plus the cost of training of adm. and designee of **$4368.00/yr for annual training. TOTAL COST OF ANNUAL TRAINING WOULD BE $6254.40/yr.!!!!**

These figures become more astronomical when you consider the high turnover of hirees, and for the larger homes with more employees.

The income of the PCH could <u>not</u> support these figures. THE ISSUE IS COMPOUNDED WITH THE HOMES WHICH HAVE SSI RESIDENTS AT $30/DAY.

THIS IS NOT FEASIBLE, AND WOULD CAUSE A DISASTEROUS ECONOMICAL IMPACT TO THE PCH, **AND TO THE RESIDENT AND THEIR FAMILIES!**

We agree that education is a valuble thing, and that it does improve the outcome of health, safety, and welfare for our residents. We agree that education will "raise the standard" BUT it must be within reason which would be economically feasible.

OUR SUGGESTION:
(1) mandate 8 hr. of nonspecified training per yr. for all direct-care staff and administrators.
OR
(2) Let the Commonwealth absorb the cost of training. DPW should provide for the training and reimburse for the lost wage while attending classes.

(4) An annual evaluation of the staff-training plan, including the extent to which implementing the plan met the identified training needs.

§2600.60. Individual staff training plan.

A written individual staff training plan for each employee, appropriate to that employee's skill level, shall be developed annually with input from both the employee and the employee's supervisor. The individual training plan shall identify the subject areas and potential resources for training which meet the requirements for the employee's position and which relate to the employee's skill level and interest.

(1) The plan shall be based upon an employee's previous education, experience, current job functions and job performance.

(2) The employee shall complete the minimum training hours as listed in §2600.58 (d) (relating to staff training and orientation) with the subject selections being based upon the needs identified in the training plan.

(3) Annual documentation of the required training in the individual staff-training plan shall be maintained for all staff.

PHYSICAL SITE

2600.60 Individual staff training plan

This section should be deleted. Staff members are required to have certain training/certifications such as first aid and CPR; therefore, the employer currently maintains this information in the personnel file. It is not necessary to create more paperwork documenting what is already being completed.

Should the employee need additional training or complete other training this could be reflected in annual employee review, if appropriate.

This section also supercedes what other health care professionals are required to do.

The staff training plan and the individual staff training plan translate into more unnecessary paperwork, more policies and procedures which comes with a high cost that will be absorbed by the resident in the end, This is harmful.

It also means less time to administer good personal care because staff will be buried in paperwork.

The hours of labor and the cost to accomplish this is directly subtracted from the health and welfare of our residents.

Does DPW have these 2 plans?

OUR SUGGESTION:
(1) For the employee file to have a record of the CEU's earned each year. We still recommend 8 hrs./yr.

§2600.81. Physical accommodations and equipment.

The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within and exiting the home.

§2600.82. Poisons.

(a) Poisonous materials shall be stored in their original, labeled containers.

(b) Poisonous materials shall be stored separately from food, food preparation surfaces, and dining surfaces.

(c) Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

§2600.83. Temperature.

(a) The indoor temperature must be a minimum of 70°F when residents are present in the home.

(b) If a home does not provide air conditioning, fans shall be made available to residents when the indoor temperature exceeds 80°F.

2600.81 Physical accommodations and equipment.

This sentence is a reflection of the influence of the nursing home administrators which they have had on much of these proposed regulations.

Because skilled nursing facilities receive Medicare benefits, they are required by Medicare to provide the equipment necessary to meet the needs of the patients which they admit. The equipment may include walkers, canes, wheelchairs, oxygen condensors or tanks, adaptive equipment etc.

PCH do NOT receive Medicare benefits, nor do we want those benefits. We should NOT have to purchase and provide such equipment. However, a home should make sure that a resident has access to his/her own equipment and that the equipment is in good repair to prevent any safety hazards.

OUR SUGGESTION:
Delete the words "and equipment".

(a) The home shall have hot and cold water under pressure in each bathroom, kitchen, and laundry area to accommodate the needs of the residents in the home.

(b) Hot water temperature in areas accessible to the resident shall not exceed 120°F.

(c) A home that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Commonwealth Department of Environmental Protection-certified laboratory, stating that the water is safe for drinking. A public water system is a system that provides water to the public for human consumption, which has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

(d) If the water is deemed unsafe for drinking, the home shall conduct remediation activity in accordance with the recommendations of the Department of Environmental Protection.

(e) The home shall keep documentation of the laboratory certification, in addition to the results and corrections made to ensure safe water for drinking.

§2600.90. Communication system.

(a) The home shall have a working, non-coin operated, telephone with an outside line that is accessible in emergencies and accessible to persons with disabilities.

2600.89 Water

(b) Hot water temperature at 120*F may be too low for a very large facility.

The hot water temperature at the beginning of the line may be 120*F., but the temperature at the end of the line, in a large facility, may drop to 108*F.

(c) This statement is already regulated by DEP.

§ 2600.101. Resident bedrooms.

(a) Each single bedroom shall have at least 80 square feet of floor space per resident measured wall to wall, including space occupied by furniture.

(b) Each shared bedroom shall have at least 60 square feet of floor space per resident measured wall to wall, including space occupied by furniture.

(c) Each bedroom for a resident with a physical immobility shall have 100 square feet per resident, or allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including but not limited to wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space.

(d) No more than four residents shall share a bedroom.

(e) Ceiling height in each bedroom shall be at least 7 feet for new homes licensed after the effective date of this act.

(f) Each bedroom shall have an operable window with a source of natural light. This window shall be able to be opened by the resident without the use of tools and shall be screened.

2600.101 Resident bedrooms.

(a) Current regulations Chapter 2620.52 requires that a single occupancy room have at least 80 sq.ft. and if a bedroom has a built in closet, up to 9 sq.ft.per closet may be counted in calculating the square footage of floor space.

This has been the standard which PCH have built rooms on.

The verbage of Chapter 2600.101 (a) does not allow the closetspace.

Rooms licensed under current regulations may not be able to accomodate this provision.

This is an example of why existing buildings need to be "grandfathered-in".

(c) This is again a change from the current 80sq.ft. for single occupancy and 60sq.ft.for shared occupancy.

The implications for this new provision is that PCH which were built with the current regs. will not be able to admit residents with physical immobilities. Then this could lead to accusations of civil rights violations!

It is ridiculous that the home would have to burden a physician for an order that would state that a resident can manuever with less space!

This regulation is actually taking away choices for the residents room preference. To reduce cost, a physically immobile resident would no longer be able to choose a semi-private room in many existing homes.

This is an example of why existing homes need to be "grandfathered-in".

OUR SUGGESTION:

DELETE (a) and (c) and use the verbage from current Chapter 2600.52 (a).

(g) A resident's bedroom shall be only for the occupying resident's individual use and not for activities common to other residents.

(h) A resident shall be able to access toilet, hand washing, and bathing facilities without having to pass through another resident's bedroom.

(i) Bedrooms shall be equipped to ensure the resident's privacy.

(j) A resident shall have access to the resident's bedroom at all times.

(k) Each resident shall have the following in the bedroom:

(1) A bed with a solid foundation and fire retardant mattress that is in good repair, clean, and supports the resident.

(2) A mattress that shall be plastic-covered if supplied by the home.

(3) Pillows and bedding that shall be clean and in good repair.

(4) A storage area for clothing that shall include a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

(l) Cots and portable beds are prohibited.

(m)Bunk beds are prohibited.

(n) A bedroom shall not be used as a means of egress from or used as a passageway to another part of the home unless in an emergency situation.

(o) A resident shall not be required to share a bedroom with a person of the opposite sex.

(p) The bedrooms shall have walls, floors, and ceilings, which are finished, clean, and in good repair.

(q) There shall be doors on the bedrooms.

(r) There shall be a minimum of one comfortable chair per resident per bedroom. The resident shall determine what type of chair is comfortable.

(s) There shall be a minimum of one operable ceiling light per bedroom or a minimum of one operable lamp per resident.

(t) There shall be drapes, shades, curtains, blinds, or shutters on the bedroom windows, which are clean, in good repair, provide privacy, and are sufficient to cover the entire window when drawn.

§2600.102. Bathrooms.

2600.101 Resident bedroom

(r) Please delete *The resident shall determine what type of chair is comfortable.* The resident may think a comfortable chair is a heated, Messaging, recliner.

(a) There shall be at least one functioning flush toilet for every six or less users, including residents, family and personnel.

(b) There shall be at least one sink and wall mirror for every six or less users, including residents, family and personnel.

(c) There shall be at least one bathtub or shower for every fifteen or less users, including residents, family and personnel.

(d) There shall be slip-resistant surfaces in all bathtubs and showers.

(e) Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

(f) An individual towel, washcloth, and soap shall be provided for each resident.

(g) Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb, and hairbrush shall be made available.

(h) Toilet paper shall be provided for every toilet.

(i) A dispenser with soap shall be provided in all of the bathrooms. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident.

2600.102 Bathrooms.

(a) The ratio of 1:6 toilets:residents is acceptable. However, the wording of this section creates a need for an interpretive guideline.
To clarify this, it should simply state "There shall be at least one functioning toilet for every six or less residents.
For "users, including residents, family, and personnel" may require that additional toilets be installed, This may be an impossibility for existing homes.
(b) and (c) Creates the same confusion. Delete "family and personnel" for clarity.

These regulations have eliminated handbars,grab bars, and exhaust fans. We feel that these are needed for bathroom safety to prevent slips and falls.

(g) Providing personal sundries should not be the responsibility of the PCH, but rather that or the family or resident's designee. The brand of products etc should remain the resident's choice, the type of products should be the resident's preference. This should not be the responsibility of the home.

(j) Toiletries and linens shall be in the possession of the resident in the resident's living space.

§2600.103. Kitchen areas.

(a) A home shall have an operable kitchen area with a refrigerator, sink, stove, oven, cooking equipment, and cabinets for storage.

(b) Kitchen surfaces shall be of a non-porous material and cleaned and sanitized after each meal.

(c) Food shall be protected from contamination while being stored, prepared, transported, and served.

(d) Food shall be stored off the floor or the lowest shelf shall be sealed to the floor.

(e) Food shall be labeled, dated, rotated, and inventoried weekly.

(f) Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers shall be required in refrigerators and freezers.

(g) Food shall be stored in closed or sealed containers.

(h) Food shall be thawed either in the refrigerator, microwave, under cool water, or as part of the cooking process.

2600,103 Kitchen areas.

(b) Remove the word "sanitized" If the kitchen is cleaned, it is not necessary to sanitize after each meal.

(c)In the small PCH which are more family-style, the foods are served from the kitchen to the table. The dishes are not covered during transport. Dishes are not covered during transport at many restuarants.

This appears to be a nursing home or hospital practice of the stainless steal / silver metal lids which cover plates. This is to protect from all the germs from illness, from the airborne pathogens

PCH are residential settings NOT institutions which collect diseased patients.

The word "transported" should be deleted.

§2600.106. Swimming areas.

If a home operates a swimming area it shall abide by the following requirements:

(1) The home shall operate swimming areas in conformity with applicable laws and regulations.

(2) The home shall develop, utilize, and implement policy and procedures that protect the health and safety of all of the residents in the home.

§2600.107. Internal and external disasters.

(a) The home shall have written emergency procedures that shall be developed and approved by qualified fire, safety and local emergency management offices.

(b) The written emergency procedures shall be reviewed and updated annually by the administrator, qualified fire, safety, and local emergency management offices.

(c) Disaster plans must include at a minimum:

(1) Contact names.

2600.107 Internal and external disasters

(b) Why do you need to change your procedures annually. Of course a disaster plan, like any plan, is a continual working and changing document and that plan should be reviewed and updated annually but generally only the administrator would need to make that update.

(a) and (b). The last "and" of both sentences needs to be changed to OR.

(e) If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, all smoke detectors and fire alarms shall be equipped so that each person with a hearing impairment will be alerted in the event of a fire.

(f) All smoke detectors and fire alarms shall be tested for operability at least once monthly. A written record of the monthly testing shall be kept.

(g) If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(h) The home's fire safety procedures must indicate the emergency procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

(i) In homes housing five or more immobile residents, the fire alarm system shall be directly connected to the local fire department or 24-hour monitoring service approved by the local fire department.

§2600.131. Fire extinguishers.

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

2600.130 Smoke detectors and fire alarms

(f) The correct method for testing smoke alarms and fire detectors of operability is to hire the company to conduct the test using smoke cans. This service cost a few hundred dollars and would be extremely cost prohibited monthly.

(g)Completed within 48 hours" may be too restrictive, as the timeframe is actually controlled by the alarm companies that service the firesytems.

We prefer the verbage from the current 2620.55 regs which states "The administrator shall immediately document improperly functioning fire safety eqipment and arrange for repair or replacement as soon as possible. The administrator shall also document steps taken to ensure the safety of residents until actual repair or replacement of the faulty equipment has been completed."

(i) This statement is repeated on page 94, 2600.123(a)

(b) There shall be a documented annual fire safety inspection and fire drill conducted by a fire safety expert. The administrator shall keep documentation of this drill and inspection.

(c) A written fire drill record shall be kept of the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff evacuated, problems encountered, and whether the fire alarm or smoke detector was operative.

(d) Residents shall be able to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within 2 1/2 minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert shall not be an employee of the home.

(e) A fire drill shall be held during sleeping hours once every 6 months.

(f) Alternate exit routes shall be used during fire drills.

(g) Fire drills shall be held on different days of the week, at different times of the day and night, on different and normal staffing shifts, not routinely held when additional staff persons are present, and not routinely held at times when resident attendance is low.

(h) Residents shall evacuate to a designated meeting place outside the building or within the fire-safe area during each fire drill.

2600.132 Fire Drills

(c) The facility may use multiple exit routes during an evacuation.

(d) Please explain and provide reference for the 2 ½ minute period for evacuations.

(e) The night time drills should be simulated drills. Again, these drills are to test the staff's ability to assist with the evacuation. The night time is very confusing and frightening for the elderly, why impose this upon the elderly.

Additional comments regarding the ~~2½ minute~~ for evacuation is needed as we feel that this could jeopardize the health, safety, and welfare or the residents. Many of the resident population are frail or disabled, and to rush/race to meet the timeframe may cause injuries related to falls, or cardiopulmonary complications associated with shortness of breath.

The larger the facility the more exagerated the complications might be due to the longer length of hallways.

When did personal care homes become continuum community-based residential long-term care services?

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 2600, 2620]

Personal Care Homes

Statutory Authority

Notice is hereby given that the Department of Public Welfare (Department), under the authority of Section 211 and Articles IX and X of the Public Welfare Code (62 P.S. §211, §§901-922 and §§1001-1087) proposes to adopt amendments to read as set forth in Annex A.

Purpose of Regulations

The proposed regulations will add a new Chapter 2600 to 55 Pa. Code to replace the existing personal care home licensing regulations at 55 Pa. Code 2620. Personal care homes are a vital and important component of the continuum of community-based residential long-term care services available to the residents of Pennsylvania. These regulations will strengthen health and safety requirements based on public input and research.

Background

The development of these proposed regulations began in the fall of 1999 as part of the Adult Residential Regulations project, a PRIME initiative to improve existing human service licensing functions within State government by strengthening health and safety protections and reducing duplication within the licensing process. PRIME – Privatize, Retain, Innovate, Modify, and Eliminate – is Pennsylvania's initiative to make state government more customer-centered, cost-efficient, and competitive.

The Department's Office of Licensing and Regulatory Management leads the Adult Residential Regulations project. The project will encompass nine chapters under the authorities of the Departments of Public Welfare and Health. The goal of the regulatory consolidation is to improve services and protections to consumers by focusing provider effort on compliance with fundamental health and safety regulations. To allow for dialogue and to obtain specific feedback from those most directly affected by this project, the Department solicited ongoing and active consultation and involvement with many providers, provider associations, residents, family members and advocacy organizations.

The Department convened initial briefing meetings with numerous statewide external stakeholders organizations from Fall 1999 to Spring 2000. In February 2001, the Department convened a statewide briefing meeting to present information regarding the scope and content of the regulations project. The Department invited legislators, statewide external stakeholders, educators, field licensing staff, providers, consumers and advocates to attend. The Department

—posted the first informal draft of the Adult Residential regulations on the Department's website in April 2001, and mailed copies to interested persons without Internet access. In May 2001, the Department convened a three-day meeting to obtain input on major issues of particular concern to all stakeholders. The Department also extended the comment period on the first informal draft of the regulations for an additional two weeks, to provide additional time for public input. The Department received comments from over 950 interested individuals regarding the first informal draft of the proposed Adult Residential regulations, with the majority of the comments from the personal care home industry.

In June 2001, after reviewing and considering the comments received, the Departments of Public Welfare, Health and Aging decided to cluster and phase in the promulgation of the Adult Residential regulations. The Personal Care Home regulations were prioritized due to the tremendous growth in the personal care home population, and the changing nature and complexity of needs and services required by these residents. In June 2001 the Department mailed all providers a letter to inform them of this decision.

In preparation of this proposed regulation for personal care homes, the Department met with its Personal Care Home Advisory Committee and external stakeholder groups. Department staff also toured personal care homes across the state to discuss the development of the proposed regulations with Personal Care Home administrators, residents, family members and staff. The Department

Why are no public hearings scheduled, as stated on page 13?

What are the 950 comments from interested individuals?

Personal care homes are not industries, they are professional businesses.

reviewed and considered all comments, and then developed a preview draft of the proposed Personal Care Home regulations.

In March 2002, the Department posted the preview of the draft Personal Care Home regulations on its website, and invited interested persons to provide comments. All comments received were reviewed and considered in developing these proposed regulations. The Department will continue to meet with Personal Care Home stakeholders.

Throughout this public input process, the Department received many valuable comments and suggestions from many external stakeholders who participated in the process. The Department values the comments submitted and has incorporated many of the suggested changes in the proposed regulation.

Significant Provisions

Reportable Incidents

At 55 Pa. Code §2600.16, the Department proposes enhanced reporting of incidents, beyond those listed in the current regulations, which will serve to protect the health, safety, and rights of residents in the home.

Waivers

The proposed provisions at 55 Pa. Code §2600.19 are intended to ensure that waivers of regulatory standards do not have a negative impact on residents. The regulation is designed to ensure that residents are informed about waiver requests and

approved waiver requests in the home in which they live. In addition, the residents are given an opportunity to provide input into the home's waiver request.

Resident-Home Contract

The proposed provisions at 55 Pa. Code §2600.26 are expanded to provide full disclosure of the contract to be signed and the resident rights. This requirement will promote good business practices, and protect the resident, his family and the facility. The additional regulatory protections include a 72-hour right of rescission of the contract, a requirement that resident's service needs are to be addressed 365 days a year, and a mandate to list the actual amount of allowable resident charges for each service item.

Resident Rights

The proposed provisions at 55 Pa. Code §2600.32 offer additional regulatory protections for the resident, listing twenty-eight specific resident rights. An appeal procedure is proposed in Section 2600.31 to allow the resident or the resident's family to file a complaint if they believe a resident's right has been violated.

Staffing

The proposed provisions at 55 Pa. Code §2600.56 maintain the current level of personal care service hours per resident, based on the resident's mobility or immobility needs. This section also proposes that if a resident's personal care needs exceed the current minimum level of personal care hours, then the home must provide a sufficient number of direct care staff to provide the necessary level of care required by the resident.

Allowing the resident to rescind the contract within 72 hours may present landlord/tenant disputes and those laws would become effective creating months of legal issues.

The number of direct care staff providing the necessary level of care required by the residents not resident.

Administrator Training and Orientation

The Department proposes at 55 Pa. Code §2600.57 to provide for greater training and competency requirements for administrators than current regulations require. Training requirements cover additional essential areas such as special populations with dementia, care of residents with mental illness and cognitive impairments and gerontology. Demonstrated competency in the training material is required. Enhanced training will provide additional health and safety protection of residents by ensuring that administrators gain knowledge and competency through training. This section proposes to expand the scope and length of the administrator training program, and also requires new administrators to successfully complete a competency-based internship in a licensed home under a Department-trained administrator. A licensed Nursing Home Administrator hired after the effective date of this rulemaking will be required to pass a competency-based training test, or attend a shortened administrator-training course, and achieve a passing grade.

Staff Training and Orientation

55 Pa. Code §2600.58 proposes to mandate greater training and competency requirements for direct care staff. The Department proposes that annual training for all staff is 24 hours and must be related to their job duties. The health and safety of residents will be enhanced by ensuring that staff gain knowledge and competency through training.

Bedrooms.

The Department proposes at 55 Pa. Code §2600.101 that residents with physical disabilities will have larger bedrooms to allow for easy passage and comfortable use of assistive devices.

Safe Management Techniques

A resident's health and safety is most at risk during a time of crisis behavior. The Department reviewed the literature and spoke with experts regarding this topic, and considered other regulations that are being applied to similar services. The positive intervention techniques proposed at 55 Pa. Code §2600.201 applied by staff are designed to assist a resident to return to safe and stable functioning.

Initial Assessment and Annual Assessment

55 Pa. Code §2600.225 proposes enhanced screening and assessments of residents, to ensure accurate evaluation of resident needs, and to prevent a resident from being inappropriately placed in a home. The proposed provisions require that the resident must be comprehensively assessed within 72 hours of admission, to identify the resident's current needs, and to ensure that the facility can meet the resident's needs.

Development of the Support Plan

After the resident's needs are assessed, the Department proposes at 55 Pa. Code §2600.226, the development of a support plan, which is a written document for each resident describing the resident's assessed care, service or treatment needs, and how those needs will be met and by whom. The support plan sets out clearly the care and

Safe management techniques generally are not a concern among the population being served in personal care homes. The safe management techniques are mental health, mental retardation, drug and alcohol issues and if this population is being served in personal care homes then include a separate unit similar to secured units.

responsibilities of the facility or outside entities in providing the services that the resident needs. In addition, the facility is required to inform the resident, the resident's family or advocate of the right to have other persons involved in the development of the support plan.

Secured Unit Requirements

55 Pa. Code §2600.229 proposes that a home that chooses to operate a secured unit for persons with dementia may open this unit without submitting a waiver for the Department's review and approval. To operate a secured unit, a facility must comply with all regulations relating to secured units set forth in this section.

Medications Administration

The Department received numerous comments on previous drafts of proposed changes for 55 Pa. Code §§2600.181-.188, concerning who may directly administer medications to residents. Currently, homes are only permitted to provide assistance with medications prescribed for self-administration. Current provisions require that only a licensed physician, nurse or dentist, as appropriate, may administer medications not prescribed for self-administration. The current provisions are retained in the proposed rulemaking. The Department received recommendations to expand the types of persons allowed to directly administer medications not prescribed for self-administration to include trained personal care home staff. As part of this recommendation, commentators recommended creating a specific medical technician training and certification program for personal care home staff. Because of state practice law and regulations, the issue of

— expanding persons able to directly administer medications not prescribed for self-administration requires review in more detail with the General Assembly, the State Board of Medicine and the State Board of Nursing. As such, the Department will review this recommendation independently from this rulemaking and, if feasible, consider a separate rulemaking in the future.

Affected Individuals, Groups and Organizations

Personal care homes must comply with these requirements to operate. The Department's survey indicates that there are 1,786 licensed personal care homes in Pennsylvania, with a licensed capacity of approximately 80,000 beds. Of this total, approximately 1,400 homes are operated for profit, and almost 400 homes are operated as nonprofit. Of the over 53,000 residents in Personal Care Homes, over 10,500 residents receive SSI benefits which is accepted as full payment towards the residents' monthly care. There are approximately 370 homes with 4 to 8 beds, approximately 370 homes with 9 to 20 beds, approximately 535 homes with 21 to 50 beds, over 300 homes with 50 to 100 beds, and over 300 homes with over 100 beds. The residents receiving care and services in these licensed facilities are directly affected by the proposed regulation since they are the consumers that the proposed rulemaking aims to protect. Families of the residents receiving care and services are affected in their interest to assure the health, safety and well-being of their loved ones.

Accomplishments/Benefits

This proposed rulemaking offers standards to improve the operation of all personal care homes in Pennsylvania, such as enhanced consumer protections, strengthened training and competency requirements for administrators and direct care staff, safe management techniques, improved screening and assessments of residents to ensure that the home can meet resident needs, expanded incident reporting, and the development of a support plan to ensure the resident's needs will be met by the facility.

Private Sector

Personal Care Home Providers

In drafting the proposed rulemaking, the Department gave careful consideration to the effect the regulation will have on the cost of providing or receiving services. The issues that will have most potential to influence the cost of implementing Chapter 2600 are the following:

1. Mandatory costs for all personal care homes:
   (a) Printing costs for policies and procedures, personnel management, quality management, and other necessary documents.
   (b) Reimbursement of residents' personal needs allowance within one week of discharge.
   (c) Annual furnace inspection.
   (d) Additional annual training costs due to additional required hours of training for administrators and staff.

2. Optional or possible costs for all personal care homes:

(a) A home with possible fire-safety violations will incur additional costs to correct the violations.

(b) Certification as a new Personal Care Home Administrator will require upgraded credentials, which may require additional salary、Training and competency-based testing.

(c) A facility with multiple buildings on the premises, that house 4 or more residents in each building, will need to meet new staffing requirements.

(d) Physical site modifications to serve residents with physical disabilities.

(e) Coliform water testing for homes not connected to a public water system.

3. Individual choice to assume cost:

(a) Those applying to be Personal Care Home Administrators for the first time must meet new educational requirements, obtain hands on experience, and complete and pass competency based testing prior to becoming a PCH Administrator.

(b) Those applying to be Personal Care Home Administrators for the first time must meet increased certification hours (from 40 hours to 60 hours).

(c) Those applying to be Personal Care Home Administrators for the first time must pay cost associated with competency-based testing for new personal care home administrators.

General Public

There will be no costs to the general public as a result of this proposed regulation.

Public Sector

Commonwealth

The Department anticipates that this proposed regulation will have no impact on state revenues. Personal care home residents who meet eligibility requirements can use government funds to pay to live in a personal care home. Approximately 10,000 low-income residents over age 65, disabled, or blind receive monthly payments from the federal Supplemental Security Income (SSI) program. In addition, the Commonwealth provides a supplement to SSI recipients. This supplement was increased by 20% (or $15 million in state dollars) for fiscal year 2001-2002.

Local Government

This proposed regulation will not impact local government.

Paperwork Requirements

The proposed regulation affects the paperwork requirements for the Commonwealth and the general public because additional paperwork is required. However, there is no reasonable alternative to the increased paperwork. Departmental forms required by the regulation, such as the intake assessment and the annual assessment forms, will be developed with input from external stakeholders prior to implementation.

The supplement to SSI was not increased by 20%. The SSI supplement was increased by $2.00 per day. If the increase was 20% then the daily amount would have been $3.91 per day.

This increase was over the last seven years not the fiscal year 2001-2002.

Effective Date

Immediately upon publication of a final rulemaking except for §2600.58 (a), (b), and (c), which will take effect one year after publication of final rulemaking.

Sunset Date

A sunset date is not anticipated because the underlying statute is permanent.

Public Hearings

Public hearings concerning the proposed regulation are not planned.

Public Comment Period

Interested persons are invited to submit written comments, suggestions or objections, regarding the proposed regulation to the Department of Public Welfare, Office of Licensing and Regulatory Management, Teleta Nevius, Director, Room 316 Health and Welfare Building, P.O. Box 2675, Harrisburg, Pennsylvania 17120, 717-705-0383 within 30 days of the date of publication of this notice in the Pennsylvania Bulletin. All comments received within 30-calendar days will be reviewed and considered in the preparation of the final-form regulation. Comments after the 30-day comment period will be considered for any subsequent revisions of this regulation.

Why are no public hearings being held when you indicate on page 3 of this letter that you received 950 comments from interested individuals?

Persons with a disability may use the AT&T Relay Service by calling (800) 654-5984 (TDD users) or (800) 654-5988 (Voice users).

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on SEP 2 3 2002, the Department submitted a copy of the proposed regulation to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Health and Human Services Committee and the Senate Public Health and Welfare Committee. In addition to submitting the proposed regulation, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

If IRRC has objections to any portion of the proposed regulation, it will notify the Department within 10 days of the expiration of the Committees' review period. The notification shall specify the regulatory review criteria that have not been met by that portion. The Regulatory Review Act specifies detailed procedures for the review of objections raised, prior to final publication of the regulation, by the Department, the General Assembly and the Governor.

FEATHER O. HOUSTOUN,

Secretary

55 PA CODE CHAPTER 2600 PERSONAL CARE HOMES

SUBCHAPTER A-GENERAL ADMINISTRATIVE REQUIREMENTS

GENERAL PROVISIONS

GENERAL REQUIREMENTS

RESIDENT RIGHTS

SUBCHAPTER B-HEALTH AND SAFETY REQUIREMENTS

STAFFING

PHYSICAL SITE

TRANSPORTATION

MEDICATIONS

SAFE MANAGEMENT TECHNIQUES

SERVICES

Chapter 2600. Personal Care Homes

SUBCHAPTER A

GENERAL

§2600.1. Purpose.

The purpose of this chapter is to assure that personal care homes provide safe, humane, comfortable, and ~~supportive residential settings~~ for dependent adults who require assistance beyond basic necessities of food and shelter but who do not need hospitalization or skilled or intermediate nursing care. Residents who live in homes meeting the standards found in this chapter will receive the encouragement and assistance they need to develop and maintain maximum independence and self-determination.

§2600.2. Scope.

(a) This chapter applies to personal care homes as defined in this chapter, and contains the minimum requirements that shall be met to obtain a license to operate a personal care home.

(b) This chapter does not apply to commercial boarding homes or to facilities operated by a religious organization for the care of clergy or other persons in a religious profession.

§2600.3. Inspections and licenses or certificates of compliance.

(a) An authorized agent of the Department shall conduct on-site inspections of personal care homes.

(b) A certificate of compliance shall be issued to the legal entity by the Department if, after an investigation by an authorized agent of the Department, the requirements for a certificate of compliance are met.

(c) The personal care home shall post the current certificate of compliance in a public place in the personal care home.

§2600.4. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Abuse - One or more of the following acts:

(i) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish,

2600.3 Inspections and licenses or certificates of compliance

(b) If a plan of action is agreed upon and completed then a certificate of compliance should be issued to the legal entity.

2600.4 Definitions

This section has expanded with 11 new definitions when compared to the current CHAPTER 2620.
A significant change is that PCH staff is now clearly categorized as ancillary or direct care staff. We like this.

The second noticeable change is in the nomenclature of: 2620.32 "personal hygiene" being converted to 2600 ADL, and
2620.33 "tasks of daily living" being converted to 2600 IADL.
The conversions are clearly from the influence of the nursing homes with the medical background. Philosophically, we disapprove of the medical-model association.
The change of terminology has not been consistent throughout the proposed 2600 regulations.

We recommend "cleaning up" the final form regulation: either use personal hygiene/tasks of daily living OR ADL/IADL

(ii) The willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health, or

(iii) Sexual harassment, rape or abuse, as defined in 35 P.S. §§10225.101-10225.502 (relating to Older Adult Protective Services Law), 6 Pa Code Chapter 15 (relating to Protective Services for Older Adults), and 23 Pa. C.S. §§6101–6117 (relating to Protection from Abuse).

(iv) Exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident.

(v) Neglect of the resident, which results in physical harm, pain or mental anguish.

(vi) Abandonment or desertion by a caretaker.

ADL - Activities of Daily Living – The term includes bathing, dressing and undressing, grooming, eating, transferring in out of bed or chair, toileting, bladder management, bowel management and additional personal care activities such as nail care and hair care.

Adult - A person who is 18 years of age or older.

Ancillary staff - A person who provides services for the home but does not provide the services provided by direct care staff.

2600.4 Definitions

abuse
(iv) Please clarify informed consent.

Agent - A person authorized by the Department or other State Agency to enter, visit, inspect, or conduct an investigation of a personal care home.

Appropriate assessment agency or agent - An organization serving the aged or disabled population, such as a county mental health/mental retardation agency, a drug and alcohol agency, an area agency on aging or another human service agency, or an individual in an occupation maintaining contact with the aged and disabled, such as medicine, nursing or rehabilitative therapies.

Commercial boarding home - A type of residential living facility providing only food and shelter, or other services normally provided by a hotel, for payment, for persons who require no services beyond food, shelter and other services usually found in hotel or apartment rental.

Complementary and alternative medications - Practices, substances, and ideas used to prevent or treat illness or promote health and well-being outside the realm of modern conventional medicine. Alternative medicine is used alone or instead of conventional medicine. Complementary medicine is used along with or in addition to conventional medicine.

Complaint - A written or verbal criticism, dispute, or objection presented by or on behalf of a resident regarding the care, operations, or management policies of a personal care home.

Department - The Department of Public Welfare of the Commonwealth.

Commercial boarding home
We prefer the verbage from Chapter 2600 which adds "...to adults who are unrelated to the owner,,,"

Designee - The person authorized to act in the absence or in capacity of another. Such authorization shall be documented in the resident's records when it concerns a resident's designee, and documented in the personnel records when it concerns the administrator's designee.

Direct care staff - A person who assists residents with activities of daily living, provides services or is otherwise responsible for the health, safety, and welfare of the residents. The term includes full and part time employees, temporary employees and volunteers.

Emergency medical plan - A plan that ensures immediate and direct access to medical care and treatment for serious injury, or illness, or both.

Financial management - A personal care service provided whenever the administrator serves as representative payee (or as a guardian or power of attorney assigned prior to December 21, 1988) for a resident, or when a resident receives assistance in budgeting and spending of the personal needs allowance. The term does not include storing funds in a safe place as a convenience for a resident.

Fire safety expert - A member of a local fire department, fire protection engineer, Commonwealth-certified fire protection instructor, college instructor in fire science, county or Commonwealth fire school, volunteer trained and certified by a county or Commonwealth fire school or an insurance company loss control representative.

The definition designee should be more clearly defined because designee can be two separate issues one the administrator's designee and two the resident's designee. One definition could blur an issue because it may become difficult in determining which designee is meant.

IADL - Instrumental Activities of Daily Living – The term includes, but is not limited to the following:

(i) Doing laundry;

(ii) Shopping;

(iii) Using transportation;

(iv) Managing money; and

(v) Using a telephone.

Immobile resident - An individual who is unable to move from one location to another, or has difficulty in understanding and carrying out instructions without the continual and full assistance of other persons, or is incapable of independently operating a device, such as a wheelchair, prosthesis, walker or cane to exit a building. The term does not mean that an immobile resident is incapable of self-administering medications.

Legal entity - A person, society, corporation, governing authority, or partnership legally responsible for the administration and operation of a home.

License - A certificate of compliance document issued by the Department permitting the operation of a personal care home, at a given location, for a specific period of time, for a specified capacity, according to appropriate Departmental program licensure or approval regulations.

Life care contract/guarantee - An agreement between the licensee and the resident that the licensee will provide care to the resident for the duration of the resident's life.

Long-term care nursing facility - A facility licensed by the Department of Health pursuant to the act of July 19, 1979 (35 P. S. §§ 448.101-448.904), known as the Health Care Facilities Act, that provides skilled or intermediate nursing care or both levels of care to two or more patients, who are unrelated to the nursing home administrator, for a period exceeding 24 hours.

Long-term care ombudsman - An agent of the Department of Aging who investigates and seeks to resolve complaints made by or on behalf of older individuals who are consumers of long-term care services. These complaints may relate to action, inaction or decisions of providers of long-term care services, of public agencies, of social service agencies, or their representatives, which may adversely affect the health, safety, welfare or rights of these consumers.

Manual restraint - Any physical means that restricts, immobilizes, or reduces a resident's ability to move his arms, legs, head, or other body parts freely except that prompting, escorting, or guiding a resident to assist in the activities of daily living shall not be construed as a manual restraint.

Mobile resident - A resident who is physically and mentally capable of vacating the home on the resident's own power or with limited assistance in the case of an emergency, including the capability to ascend or descend stairs if present on the exit path. Limited physical assistance means assistance in getting to one's feet, into a wheelchair, walker, or prosthetic device. Verbal assistance means giving instructions to assist the resident in vacating the home. The term includes a person who is able to effectively operate a device required for moving from one place to another, and able to understand and carry out instructions for vacating the home.

Neglect - The failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health. An adult who does not consent to the provision of protective services shall not be found to be neglected solely on the grounds of environmental factors which are beyond the control of the adult or the caretaker, such as inadequate housing, furnishings, income, clothing, or medical care.

Personal Care Home (home) - A premise in which food, shelter, and personal assistance or supervision are provided for a period exceeding twenty-four hours, for four or more adults who are not relatives of the operator, who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation of a home in the event of an emergency, or medication prescribed for self-administration.

Personal care home administrator (administrator) - An individual who is charged with the general administration of a personal care home, whether or not the individual has an ownership

interest in the home, and whether or not functions and duties are shared with other individuals.

Personal care resident (resident) - A person, unrelated to the licensee, who resides in a PCH and who may require and receive personal care services but does not require the level of care provided by a hospital or long-term care facility.

Personal care services - Assistance or supervision in matters, such as dressing, bathing, diet, financial management, evacuation of a resident in the event of an emergency, or medication prescribed for self-administration.

Premises - The grounds and buildings on the same grounds, in proximity, used for providing personal care services.

Referral agent - An agency or individual who arranges for or assists, or both, with placement of a resident into a personal care home.

Relative - A spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, or nephew.

Restraint - A chemical or mechanical device used to restrict the movement or normal function of an individual or a portion of the individual's body. Mechanical devices used to restrain include geriatric chairs; posey; chest, waist, wrist or ankle restraints; locked restraints; and locked doors to prevent egress. The term does not include devices used to provide support for the

achievement of functional body position or proper balance as long as the resident can easily remove the device.

(i) Chemical restraint is the use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior.

(ii) Drugs administered on a regular basis, as prescribed by a physician for the purposes of treating the symptoms of mental, emotional or behavioral disorders and for assisting the resident in gaining self-control over impulses, are not to be considered chemical restraints.

State agency - Any executive agency or independent agency as defined by the Administrative Agency Law, 2 Pa. C.S. §101.

Support plan-SP - A written document for each resident describing the resident's care, service, or treatment needs, and when the care, service, or treatment will be provided, and by whom.

Volunteer - A person who, of his own free will, and without monetary compensation, provides services for residents in the home. Volunteers who perform direct care services must meet the minimum qualifications and training of staff persons. Residents receiving personal care services who voluntarily perform tasks in the home are not to be considered volunteers for the purpose of determining compliance with the staffing requirements of this chapter.

§2600.5. Access requirements.

(a) The department will have the right to enter, visit, and inspect any home licensed or requiring a license and shall have full and free access to the records of the home and to the residents therein and full opportunity to interview, inspect, or examine such residents.

(b) The administrator and staff shall provide, upon request, immediate access to the home, the residents, and the residents' records to agents of the Department or other State Agencies, representatives of the Department of Aging's Older Adults Protective Services Program, and the Long-Term Ombudsman Program.

(c) The administrator shall permit a resident's relatives, community service organizations and representatives of community legal services programs to have access to the home during the home's visitation hours or by appointment for the purpose of visiting, or assisting or informing the residents of the availability of services and assistance.

GENERAL REQUIREMENTS

§2600.11. Procedural requirements for Licensure or Approval of homes.

(a) Except for §§20.31 and 20.32, the requirements of Chapter 20 (relating to licensure or approval of facilities and agencies) shall apply to all homes.

2600.5 Access requirements.

(a) The word *shall* has been replaced with this word *will*. Why do we need such strong language ? It is not consistent throughout the document.

There is no time frame explaining when the department will have access. Unless the department has reasonable question relating to a violation, then access should be during normal business hours.

(b) The staff should not be permitted to have access to all records, including personnel files, as this information is confidential. The staff will have access about the health of the residents, insurance information, emergency contact, next of kin, and power of attorney, but not necessarily financial records of the resident.

Please be more specific about who is meant by *other State Agencies*; this could force a home to give information about a resident to DEP, State Police, Emergency Management, Liquor Control Broad, etc. so anyone working for the state would be able access the facility and obtain any information.

2600.11 Procedural requirements for Licensure or Approval of homes.

(a) The annual inspections should remain as announced inspections because certain information including personnel records, payroll, or income reports are confidential and not all employees will have this information.

(b) Personal care homes shall be inspected as often as required by 62 P.S. §211 (l), and more often as necessary. After initial approval, homes need not be visited or inspected annually except that the Department will schedule inspections in accordance with a plan that provides for the coverage of at least seventy-five percent of the licensed homes every two years and all homes shall be inspected at least once every three years.

§2600.12. Appeals.

Appeals related to the licensure or approval of the home shall be made in accordance with 1 Pa. Code Chapters 31, 33 and 35 (relating to General Rules of Administrative Practice and Procedure).

§2600.13. Maximum capacity.

(a) The licensed capacity is the total number of residents who are permitted to reside in the personal care section of the home at any time. A request to increase the capacity shall be submitted to the Department and other applicable authorities and approved prior to the admission of additional residents. The licensed capacity is limited by physical plant space, zoning, and other applicable statutes and regulations.

(b) The maximum capacity specified on the license or certificate of compliance shall not be exceeded.

2600.11 Procedural requirements for Licensure or Approval of homes.
(b) A home may not be inspected for three years and many problems could occur during this period of time which will go unfounded. Why are we being over regulated and under inspected.

Less inspections would NOT ensure the health, safety, and welfare of our residents. We feel strongly that this could have an adverse effect.

Our recommendation: To keep Chapter 2620, but increase the inspections to every 6 months.

This not only has a direct impact on the health, safety, and welfare of our residents, but it also has an economical impact on the Commonwealth. More inspectors will be needed to review the mountains of paperwork that these regulations will require. We are unable to give an estimate of what this will cost the Commonwealth, but feel that it would be in excess of $160,000 per year.

§2600.14. Fire safety approval.

(a) Except in the cities of Scranton, Pittsburgh and Philadelphia, a home shall have written fire safety approval prior to issuance of a certificate of compliance. Written fire safety approval shall be from either the Department of Labor and Industry or the Department of Health of the Commonwealth. In the cities of Scranton, Pittsburgh, and Philadelphia, a home shall have written fire safety approval prior to issuance of a certificate of compliance from the appropriate department of public safety. In cases where fire safety approval is not required by these agencies, a valid written fire safety approval from a fire safety expert is required.

(b) If the fire safety approval is withdrawn or restricted, the home shall notify the Department orally within 24 hours and in writing within 48 hours of the withdrawal or restriction.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the home shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 30 days of the completion of the renovation or alteration.

(d) Authorized agents of the Department will request additional fire safety inspections by the appropriate agency if, during an inspection, an authorized agent observes possible fire safety violations.

(e) A home shall be in compliance with applicable Federal, State, and local statutes, ordinances, and regulations, including those statutes or regulations pertaining to fire and panic.

§2600.15. Abuse reporting covered by statute.

(a) The home shall immediately report suspected abuse of a resident served in the home in accordance with 35 P.S. §§10225.701-10225.707 (relating to Older Adult Protective Services Law) and 6 Pa. Code §15.21-15.27 (relating to reporting suspected abuse).

(b) If there is an allegation of abuse of a resident involving the home's staff, the home shall immediately implement a plan of supervision or suspension of the staff person and shall submit to the personal care home regional field licensing office a plan of supervision or notice of suspension of the affected staff person.

§2600.16. Reportable incidents.

(a) A reportable incident includes, but is not limited to, the following:

(1) The death of a resident due to accident, abuse, neglect, homicide, suicide, malnutrition, dehydration, or other unusual circumstances.

(2) Attempted suicide by a resident.